

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 11251

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elma ELMA Ruth Adkins		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR March 7 1925		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	
3 SEX Female		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co MD.	
10. CITY OR TOWN OF DEATH ELKTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital of Cecil County		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurses Aide		12b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
13a. STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Charlestown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles VanDyke		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Meadows		13e. STREET ADDRESS 253 Black Avenue		21921	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 199 14 2233		17. INFORMANT ADDRESS Paul G. Adkins, 441 W. Lewis Shore Rd, Elkton, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Klebsiella peritonitis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>portal hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Laennec's cirrhosis</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 yr.</u> <u>10 yrs.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>4/3</u> 19 <u>87</u> to <u>4/3</u> 19 <u>87</u> , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Andrew Fridberg MD</u>				DEGREE MD		22c. DATE SIGNED 4/3/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Andrew Fridberg MD				22e. ADDRESS ELKTON MD 21921			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/7/87		23c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hopewell, Cecil Md.	
24. FUNERAL DIRECTOR'S NAME Hicks Home for Funerals				25a. DATE REC'D. BY REGISTRAR APR 7 1987		25b. REGISTRAR'S SIGNATURE <u>John F. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from the register. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

410

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 1 2 5 2

1 - STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		CERTIFICATE OF DEATH		8711252		REG. NO.					
1. DECEASED NAME (Type or print)				2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
WALTER B. ALEXANDER				4-13-87								7:45 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Male		White		July 24 1923		63 YRS.		MONTHS		DAYS		HOURS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Elkton, Md.		U.S.A.				Cecil						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If not in such facility, give street address)		12a. USUAL OCCUPATION (Type of work for most of working life)		12b. KIND OF BUSINESS OR INDUSTRY							
PERRY POINT MD.		VA MEDICAL CENTER		Carpenter		Const.							
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Md.				Cecil		North East		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1704 Turkey Point Rd.			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
David Alexander				Susie A. Sharp								21901	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give branch and dates)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
YES				219 10 0582		Ruth V. Alexander		04 Turkey Point					
						North East, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u>													
DUE TO, OR AS A CONSEQUENCE OF													
(b) _____													
DUE TO, OR AS A CONSEQUENCE OF													
(c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, Part I or Part 2)					
				HOUR A.M. MONTH DAY YEAR									
				P.M. 19									
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, street, factory, office, farm, etc.)				21f. LOCATION					
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>								CITY OR TOWN COUNTY STATE					
22. I certify that (this hospital) attended the deceased from <u>APRIL 13</u> , 19 <u>87</u> , to <u>APRIL 13</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE				DEGREE				22c. DATE SIGNED					
Kevin M. Miller MD								4-13-87					
22d. PHYSICIAN'S NAME (Type or print)				22e. ADDRESS									
KEVIN MILLER M.D.				VA Medical Center, Perry Point, Md.									
23a. BURIAL, CREMATION, REMOVAL				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
Burial				4-16-87		North East Meth.				North East Cecil, Md.			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
CROUCH FUNERAL HOME NORTH EAST MD.				APR 15 1987				[Signature]					

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050323

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/B4  
(VRA 15, 4)1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 7 1 1 2 5 3  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Eleanor M. Allen</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>April 7, 1987</b>		2b. HOUR <b>M</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>March 21 1923</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Elkton</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Hospital of Cecil County</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Food Service</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>	
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Cecil</b>	13c. CITY OR TOWN <b>Elkton</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>252 W. High Street 21921</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Hammond</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Edna Lippencott</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>212-18-8623</b>	17. INFORMANT ADDRESS <b>Gerald L. Bungard, 252 W. High St., Elkton, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic obstructive lung disease, Diabetes mellitus</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary Heart failure. Atherosclerotic Heart disease</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>4/11</b> 19 <b>78</b> to <b>4/7</b> 19 <b>87</b> , that (1) (we) last saw the deceased alive on <b>4/7</b> 19 <b>87</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) did not view the body after death.					
22b. SIGNATURE <b>Dr. Jui-Chih Hsu</b>	DEGREE <b>M.D.</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/8/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Jui-Chih Hsu, M. D.</b>		22e. ADDRESS <b>223 W. Main St., Elkton, Md. 21921</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>4/10/87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cherry Hill Methodist</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cherry Hill Cecil Md.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Rick's Home for Funerals Elkton, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 10 1987</b>	25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 2 and 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

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... of the ...  
... of the ...

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 11254  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR				
FIRST	MIDDLE	LAST	MONTH	DAY	YEAR			M		
Carl Arthur Ball			April 9 1987							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		
male		white		MONTH DAY YEAR 3 2 1911		76		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Virginia		USA				Cecil County MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Elkton		Union Hospital				coal miner		mining		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Maryland			Cecil		Conowingo		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		113 E. Red Hill Road 21918	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST Fullen Ball			FIRST MIDDLE LAST Josie Ball							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS			
no			n/a		710-09-6570 Jane D. Ball		113 E. Red Hill Road Conowingo, MD 21918			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Obstructive Pulm. Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>Sec. Abdominal Abscess</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) this hospital attended the deceased from <u>Feb. 1986</u> , to <u>4.10.1987</u> , that (1) (we) lost saw the deceased alive on <u>4.10.1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Sheelmoan S. Sachdev</u>			DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>4.13.87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>SHEELMOAN S. SACHDEV</u>			22e. ADDRESS <u>802 Bow St Elkton MD 21921</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial			4/13/87		West Nottingham		Colorado Cecil Maryland			
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
R.T. FOARD F.H.			1115 Queen Rising Sun MD			APR 15 1987		<u>Julia Davidson-Rodgers</u>		

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4/20



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23.61.4

POSITION 100000 100000

23.61.4

POSITION 100000 100000



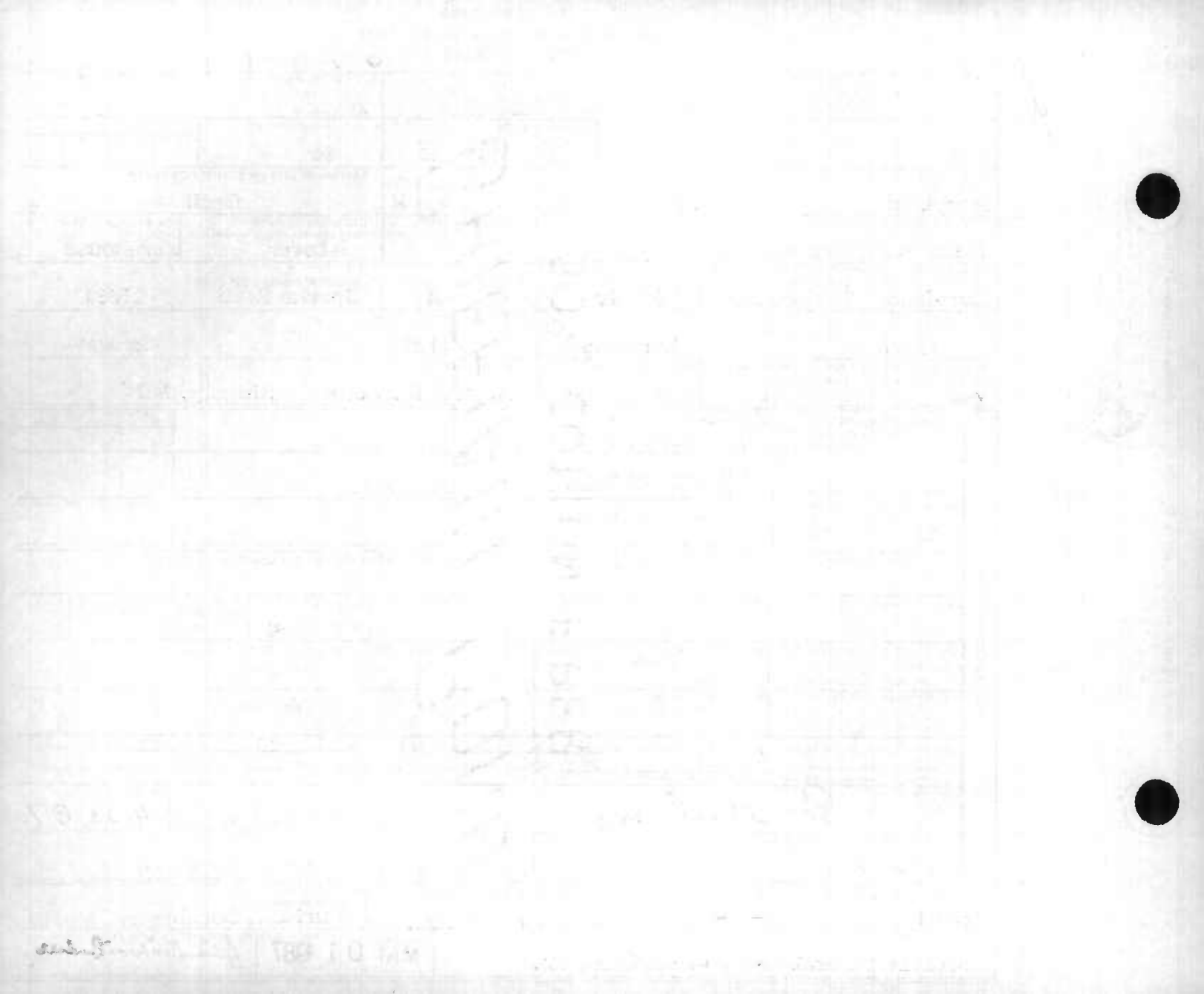
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified for autopsy.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HENRY G BARNETTE SR					2a. DATE OF DEATH MONTH DAY YEAR APRIL 23 1987		2b. HOUR 11:30PM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 10 26		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.			
10. CITY OR TOWN OF DEATH PERRY POINT MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) laborer		12b. KIND OF BUSINESS OR INDUSTRY warehouse	
13a. STATE Maryland		13b. COUNTY Caroline		13c. CITY OR TOWN Ridgely		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Sparks Road 21660	
14. FATHER'S NAME FIRST MIDDLE LAST Jarvis				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mabel Conway					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes WW II				16b. SOCIAL SECURITY NO. 220 12 4435		17. INFORMANT ADDRESS Michael Barnette Ridgely, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) C A OF LARYNX WITH METASTASIS DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12 2 19 86, to 4 23 19 87, that (I) (we) lost saw the deceased alive on 4 23 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Prem Lal M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4-23-87.	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PREM LAL				22e. ADDRESS VA MEDICAL CENTER PERRY POINT MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-28-87		23c. NAME OF CEMETERY OR CREMATORY MD Veterans' Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Hurlock Dorchester MD			
24. FUNERAL DIRECTOR NAME ADDRESS Boulais Funeral Home, Greensboro, MD.						25a. DATE REC'D. BY REGISTRAR MAY 01 1987		25b. REGISTRAR'S SIGNATURE Julia Deaton-Randall	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been reviewed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to registration, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, death, or traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR		8 7		REG. NO. 1 1 2 5 6									
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
MORRIS L ee BLICKENSTAFF				APRIL 22		1987		4:05P		M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		March 7 1918		69		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		USA				Cecil County						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
PERRY POINT MD		VA MEDICAL CENTER PERRY POINT MD		Watchmaker.									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
Maryland		Cecil		Perryville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Perryville Industrial Park					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
John Caleb		Ann Marie											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
Yes		215 05 6734		Jean W. Blickenstaff, 4530 Long Green Rd.,		21092							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASPIRATION PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>ALZHEIMER'S DISEASE; NASOGASTRIC TUBE STATUS</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>DECEMBER 2</u> , 19 <u>86</u> , to <u>APRIL 22</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>APRIL 22</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		22c. DATE SIGNED									
<i>John Lonergan</i>				4-23-87									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
JOHN LONERGAN, M.D.		VA Medical Center, Perry Point, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		4/25/87		Dulaney Valley Cem.		Timonium Balto. Md.							
24. FUNERAL DIRECTOR		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
J. E. Lowell Lemmon		APR 27 1987		<i>Julia Benson-Randall</i>									
L. M. WEIDERT		10 W. PADONIA RD		TIMONIUM MD									

ALZHEIMER DISEASE

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 1257

1. DECEASED NAME (TYPE OR PRINT) <b>AUGUST H. BORCHARDT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>April 29, 1987</b>		2b. HOUR <b>1:05pm</b>
3 SEX <b>Male</b>	4 RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>3 13 1928</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>59</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil County, MD.</b>	
10 CITY OR TOWN OF DEATH <b>Perry Point, Md.</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA Medical Center</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>
13a. STATE <b>Michigan</b>		13b. COUNTY <b>Bay</b>	13c. CITY OR TOWN <b>Bay City</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>August Borchardt</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ethel Sharpe</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Korea 375-22-8032</b>		17 INFORMANT ADDRESS <b>Bay City, Michigan</b> <b>William Borchardt 12227 North Erie Street</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Thrombo-embolism, massive, right pulmonary artery</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Aspiration of gastric contents</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Carcinoma of prostate, advanced</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 17, 1987</b> to <b>April 29, 1987</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If ventral and non-view the body after death.)					
22b. SIGNATURE <b>Roy W. Chesnut</b>		DEGREE <b>170</b>		22c. DATE SIGNED <b>4-30-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROY W. CHESNUT, M.D.</b>		22e. ADDRESS <b>VA Medical Center, Perry Point, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>5-4-87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Green Ridge Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bay City, Bay, Michigan</b>	
24. FUNERAL DIRECTOR NAME <b>Marzullo Funeral Service</b>			25a. DATE REC'D. BY REGISTRAR <b>MAY 5 - 1987</b>		

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 11253

1. DECEASED NAME (TYPE OR PRINT) <b>Betty Ann Bowman</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>April 22, 1987</b>		2b. HOUR <b>M</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 13 1934</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <b>53</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Nebraska</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Elkton</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Devine Haven Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Cook</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Cecil</b>	13c. CITY OR TOWN <b>Elkton</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Percy Crook</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Erma D. Pierce</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>519 32 0968</b>		17. INFORMANT ADDRESS <b>Tammy L. Hanlon, Elkton, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Anisotropic Lateral Sclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Year</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Pneumonias</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Dr. Robert Denitzio</b>				22c. DATE SIGNED <b>4/28/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Robert Denitzio, M. D.</b>				22e. ADDRESS <b>Route 213, Cecilton, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/25/87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gilpin Manor Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pk. Elkton Cecil Md.</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Hicks Home for Funerals Elkton, Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>APR 30 1987</b>		
			25b. REGISTRAR'S SIGNATURE <b>Robert Denitzio</b>		

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copy and return it to the funeral director. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause of death.

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

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CONFIDENTIAL



052016 APR 30 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card on pages 1 and 2 and place in box within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Leroy Bowman</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>April 17, 1987</b>		2b. HOUR <b>1:40A M</b>		
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 14, 1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> MD.	
10. CITY OR TOWN OF DEATH <b>Perry Point, Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA Medical Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Landscaper</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Nursery</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Seat Pleasant</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry Bowman</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Irene Broadus</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES <b>Yes WW II</b>		16b. SOCIAL SECURITY NO. <b>214 16 0243</b>	
17. INFORMANT ADDRESS <b>VAMC, Perry Point, Maryland</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonitis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic cardio vascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Old Hemiplegia -Cerebral vascular accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Dementia</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (b) (this hospital) attended the deceased from <b>4-16-1987</b> , to <b>4-17-1987</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>4-17-1987</b> , and that in <b>xx</b> (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did (do) not view the body after death.							
22b. SIGNATURE <b>G. Rayson</b>		DEGREE <b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>4-17-87</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GLENDON RAYSON, M.D.</b>		22e. ADDRESS <b>VAMC, Perry Point, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <b>4/23/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CHELTENHAM VETS. CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>CHELTENHAM P.G. MD.</b>	
24. FUNERAL DIRECTOR NAME <b>Henry S. Washington &amp; Son, Inc., Washington,</b>		ADDRESS <b>DC</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 28 1987</b>		25b. REGISTRAR'S SIGNATURE <b>J. J. Davidson-Randall</b>	



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

050438

1- FOR item 5, film G627 STATE REGISTRAR 5-8-87 I.J.		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		87 REG. NO. 11260	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VICTORIA BRUKIEWA			2a. DATE OF DEATH MONTH DAY YEAR April 13 1987		2b. HOUR 12:25 P.M.
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 14, 1890	
6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland		8. CITIZEN OF WHAT COUNTRY? U.S.A.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland		10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital of Cecil County	
12. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE Maryland		12b. COUNTY Cecil		12c. CITY OR TOWN Elkton	
13. FATHER'S NAME Francis		13. MOTHER'S MAIDEN NAME Rozoblia		13. STREET ADDRESS / ZIP CODE 139 River Road 21921	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		14. SOCIAL SECURITY NO. 218 05 5068		15. INFORMANT ADDRESS Annette Ott, 139 River Rd., Elkton, Md. 21921	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (a) (this hospital) attended the deceased from <u>11/13</u> 19 <u>84</u> to <u>4/13</u> 19 <u>87</u> , that (b) (we) last saw the deceased <u>10/29</u> 19 <u>86</u> , and that (c) (our) opinion of death occurred on the date and hour and from the causes stated above (b) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Jui-Chih Hsu</u>		DEGREE MD		22c. DATE SIGNED 4/13/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Jui-Chih Hsu, M.D.		22e. ADDRESS 223 W. Main St., Elkton, Md. 21921			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/15/87		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus	
23d. LOCATION CITY OR TOWN Baltimore,		COUNTY Frederick		STATE Md.	
24. FUNERAL DIRECTOR Hicks Home for Funerals,		25a. DATE OF DEATH APR 15 1987			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

051448 APR 26 1987

1- FOR STATE REGISTRAR

REG. NO. 87 11251

1 DECEASED NAME (TYPE OR PRINT) FLORENCE AGNES CALLAHAN			2a. DATE OF DEATH MONTH DAY YEAR 4/19/87		2b. HOUR 16:30 M
3 SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 7 30 1893		6 AGE (IN YEARS LAST BIRTHDAY) 93 YRS	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.	
10. CITY OR TOWN OF DEATH EIKton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY --	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Catonsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST George W. Hennick			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Jones		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-74-2641		17. INFORMANT ADDRESS Elmer G. Gallaway P.O. 336 Tuckahoe, N.J. 08250	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO, OR AS A CONSEQUENCE OF (b) Pyelonephritis DUE TO, OR AS A CONSEQUENCE OF (c) Dementia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4/19 19 87, to 4/19 19 87, that (I) (we) lost the deceased alive on 4/19 19 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22b. SIGNATURE Joseph Lanza		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/19/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph Lanza		22e. ADDRESS 721 Bridge St. EIKton, Md. 21221			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4/22/87	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS 21229 Hubbard Funeral Home, Inc. 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR APR 22 1987			
		25b. REGISTRAR'S SIGNATURE Julia Jordan-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH1 - FOR  
STATE  
REGISTRAR

87 REG. NO. 1 2622

1. DECEASED NAME (TYPE OR PRINT) WALTER H. CANNON			2a. DATE OF DEATH MONTH DAY YEAR APRIL 16 1987		2b. HOUR M
3 SEX MALE	4. RACE CAUC.	5. DATE OF BIRTH MONTH DAY YEAR JAN. 9 1917	6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) FARMINGTON DEL.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH CECIL MD.		
10. CITY OR TOWN OF DEATH ELKTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION HOSPITAL OF CECIL CO.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TAXI OWNER	12b. KIND OF BUSINESS OR INDUSTRY BAR	
13a. STATE MARYLAND		13b. COUNTY CECIL	13c. CITY OR TOWN EASTVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE BOX 102 CRYSTAL BEACH 21919
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES CANNON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDNA THOMAS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES/NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 222-01-2439	17. INFORMANT ADDRESS CARRIE O. CANNON wife same		
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) atherosclerotic coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from 7-1 19 85, to 4-16 19 87, that (2) (we) lost saw the deceased alive on 4-14 19 87, and that in (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Kenneth Lewis MD			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 4/18/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. KENNETH LEWIS			22e. ADDRESS 12 Pennington St Middletown DE 19709		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE apr 20 1987	23c. NAME OF CEMETERY OR CREMATORY GRACELAWN MEM PK	23d. LOCATION CITY OR TOWN COUNTY STATE WILLINGTON N.C. DEL.		
24. FUNERAL DIRECTOR NAME ADDRESS FELLOWS F.H. BOX 270 MILLINGTON, MD 21651			25a. DATE RECD. BY REGISTRAR APR 23 1987	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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at least 1000 years old  
and 1000 years old

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TO HOSPITAL OR ATTENDING PHYSICIAN: The physician certifies that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (This page should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.)

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be called at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

REG. NO. 11263

1. DECEASED NAME (TYPE OR PRINT) <b>ANNA Elizabeth Chinski</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4/9/87</b>			7b. HOUR <b>9:29 A</b>						
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Jan 11 1922</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil Co</b> MD						
10 CITY OR TOWN OF DEATH <b>Elkton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Hospital of Cecil County</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Cecil</b>		13c. CITY OR TOWN <b>Elkton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>11 Pinder Ave. 21921</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Ambrose</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Pasakonis</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>222 07 9958</b>		17 INFORMANT ADDRESS <b>Mrs. Edward J. Chinski, Jr., Elkton, Md. 21921</b>							
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction Suspected</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial MI - Late - Lateral wall MI</b> DUE TO, OR AS A CONSEQUENCE OF <b>Hypertension</b> (c) <b>Recent</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) (this hospital) attended the deceased from <b>3/24</b> , 19 <b>81</b> , to <b>4/9</b> , 19 <b>87</b> , that (1) (we) lost saw the deceased alive on <b>3/31</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Sargent J. K. Patel MD</b>						DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/8/87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jay K. Patel MD</b>						22e. ADDRESS <b>ELKTON MD 21921</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>4/13/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>All Saints Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Wilmington New Castle De.</b>				
24. FUNERAL DIRECTOR NAME <b>Hicks Home for Funerals</b> ADDRESS <b>Elkton, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>APR 14 1987</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Anderson</b>				

MEDICAL CERTIFICATION

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4/16

MSB 11 401 00 2002

NEW YORK



Handwritten signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified of such.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 11264	
1. DECEASED NAME (TYPE OR PRINT) FIRST Anna MIDDLE Marie LAST Collins			2a. DATE OF DEATH MONTH DAY YEAR Apr 8 87			2b. HOUR 3:00 PM					
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR March 26 1907		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.					
10. CITY OR TOWN OF DEATH Chesapeake City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 421 Biddle Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Market Owner		12b. KIND OF BUSINESS OR INDUSTRY Retail			
13a. STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Chesapeake City		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS / ZIP CODE 421 Biddle Street 21915			
14. FATHER'S NAME FIRST Ellis MIDDLE LAST Tawes			15. MOTHER'S MAIDEN NAME FIRST Martha MIDDLE LAST Hitchens								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 219 56 7419		17. INFORMANT ADDRESS Lewis A. Collins, Jr., Ches. City, Md. 21915						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Naso pharyngeal Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>one year.</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the hospital) attended the deceased from <u>Oct</u> 19 <u>86</u> to <u>Apr 8</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>Apr 8</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Wallace Obenshain MD</u>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>4-9-87</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Wallace Obenshain MD</u>			22e. ADDRESS <u>Cecilton, md</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/11/87		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Ches. City Cecil Md.				
24. FUNERAL DIRECTOR <u>Hicks Home for Funerals</u>			ADDRESS Elkton, Md.		25a. DATE REC'D. BY REGISTRAR APR 14 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>				

MEDICAL CERTIFICATION

4/16

2082 COLLECTOR FIBER

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 2, 3, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE BODY. PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 2 AND 3 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2655	
1- STATE REGISTRAR										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 4 17 19 87	2b. HOUR OF DEATH 9:43 AM
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JERALD M. CROSSAN Jr.										2c. DATE PRONOUNCED DEAD 4 17 19 87	2d. HOUR OF DEATH 9:43 AM
3 SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 10 8 59	6. AGE (IN YEARS LAST BIRTHDAY) 27 YRS.	IF UNDER 1 YR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD	
10. CITY OR TOWN OF DEATH Rising Sun			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 274			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mail handler		12b. KIND OF BUSINESS OR INDUSTRY Postal			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE PA		13b. COUNTY Chester		13c. CITY OR TOWN Lincoln Univ.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Box 25 Saddle Hill Road 99999			
14. FATHER'S NAME FIRST MIDDLE LAST Jerald M. Crossan, Sr.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Rees						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) unknown			16b. SOCIAL SECURITY NO. 221-44-9742		17. INFORMANT ADDRESS Kathleen Crossan Saddle Hill Road Lincoln Univ. PA						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:50 4-17- 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver of pick-up truck/tractor trailer collision						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 274 east of Rising Sun, Cecil MD						
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE [Signature]			TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER					DATE SIGNED 4-18-87			
EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D.			ADDRESS 111 Penn St., Balto., MD 21201								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-21-87		23c. NAME OF CEMETERY OR CREMATORY All Saints			23d. LOCATION CITY OR TOWN COUNTY STATE Wilmington Cecil Delaware			
24. FUNERAL DIRECTOR NAME R.T. Foard Funeral Home			ADDRESS Rising Sun Maryland		25a. DATE REC'D. BY REGISTRAR APR 21 1987		25b. REGISTRAR'S SIGNATURE [Signature]				

100-11113

WILLIAM

DEER HOLLOW



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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATHFOR  
1- STATE  
REGISTRAR

REG. NO.

11266

1. DECEASED NAME (TYPE OR PRINT) <b>Hobert Edward Dalton, Jr.</b>		2a. DATE KNOWN OF DEATH X MONTH DAY YEAR <b>4 4 87</b>		2b. HOUR <b>4:50 PM</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept 17 1932</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>54 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Elkton</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1520 E. Old Philadelphia Rd.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Electrician</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Cecil</b>		13c. CITY OR TOWN <b>Elkton</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Hobert E. Dalton, Sr.</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Minnie Lee Simpson</b>		17. INFORMANT ADDRESS <b>Elsie V. Dalton, 1520 E. Old Phila Rd, Elkton</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>229 42 1702</b>		17. INFORMANT ADDRESS <b>Elsie V. Dalton, 1520 E. Old Phila Rd, Elkton</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atherosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>J. C. Gonzalez-Vital</b>		TITLE (SPECIFY) <b>Deputy</b>		DATE SIGNED <b>4/4/87</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Juan C Gonzalez-Vital, MD</b>		ADDRESS <b>Union Hosp., Elkton MD 21921</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/8/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gilpin Manor Memorial Pk.</b>	
24. FUNERAL DIRECTOR NAME <b>Hicks Home for Funerals</b>		24. FUNERAL DIRECTOR ADDRESS <b>Elkton, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 10 1987</b>	
25b. REGISTRAR'S SIGNATURE <b>J. C. Gonzalez-Vital</b>					

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, AND 4 TO THE FUNERAL DIRECTOR. GIVE PAGES 5 AND 6 TO THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 4 AND 5 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10-2. PAGES 6 AND 7 SHOULD BE FILED WITHIN 72 HOURS OF DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC. NO. 11267  
4207

1- FOR STATE REGISTRAR

2. DECEASED NAME (TYPE OR PRINT) **Oscar Carpenter Davis**

3. SEX **Male** 4. RACE **White** 5. DATE OF BIRTH **2/24/1919** 6. AGE (IN YEARS) **68** 7. DATE OF DEATH **4/20/87** 8. TIME OF DEATH **4:20** 9. HOUR **PM**

10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) **Delaware** 11. CITIZEN OF WHAT COUNTRY? **U.S.A.** 12. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 13. BALTIMORE CITY OR COUNTY OF DEATH **Cecil County**

14. CITY OR TOWN OF DEATH **Rising Sun** 15. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION **47 Cherry Street** 16. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) **Retired** 17. KIND OF BUSINESS OR INDUSTRY **Laborer**

18a. STATE **Md.** 18b. COUNTY **Cecil** 18c. CITY OR TOWN **Rising Sun** 18d. INSIDE CITY LIMITS? ☒ YES ☐ NO 18e. STREET ADDRESS **47 Cherry Street**

19. FATHER'S NAME **Oscar Davis Sr.** 20. MOTHER'S MAIDEN NAME **Edna Cook**

21a. WAS DECEASED EVER IN U.S. ARMED FORCES? **Yes** (IF YES, GIVE TYPE AND DATES) **WWII** 21b. SOCIAL SECURITY NO. **303-20-3064** 21c. INFORMANT **E. David Silverberg** ADDRESS **#5 Light St. Baltimore Md.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **Atherosclerotic heart disease**  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:  
(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF  
(c) \_\_\_\_\_

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  
**Chronic obstructive pulmonary disease**

19a. DATE OF OPERATION \_\_\_\_\_ 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? \_\_\_\_\_ 20. AUTOPSY? ☐ YES ☒ NO

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 \_\_\_\_\_ 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) \_\_\_\_\_

21d. INJURY OCCURRED WHILE ☐ AT WORK ☐ NOT WHILE ☐ AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) \_\_\_\_\_ 21f. LOCATION STREET CITY OR TOWN COUNTY STATE \_\_\_\_\_

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE **[Signature]** TITLE (SPECIFY) **Deputy** M.D. MEDICAL EXAMINER DATE SIGNED **4/20/87**

EXAMINER'S NAME (TYPE OR PRINT) **Juan C Gonzalez-Vital, MD** ADDRESS **Union Hospital, Elkton MD 21921**

23a. BURIAL, CREMATION, REMOVAL (TYPE) **Burial** 23b. DATE **APR 27 1987** 23c. NAME OF CEMETERY OR CREMATORY **Elkton Cemetery** 23d. LOCATION CITY OR TOWN **Elkton** COUNTY **Cecil** STATE **MD**

24. FUNERAL DIRECTOR NAME **Gee Funeral Home** ADDRESS **259 E. Main St. Elkton** 25a. DATE REC'D. BY REGISTRAR **APR 27 1987** 25b. REGISTRAR'S SIGNATURE **[Signature]**

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 48 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSMITTAL. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. MORTIMER STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. MORTIMER ST., BALTIMORE, MD. 21201

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 11208

1. DECEASED NAME (TYPE OR PRINT) JOSEPH J. DeFELIPPO			2a. DATE OF DEATH MONTH DAY YEAR April 1, 1987		2b. HOUR 11:20am
3. SEX male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Feb. 2 1919		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.	
10. CITY OR TOWN OF DEATH Perry Point, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Printer	12b. KIND OF BUSINESS OR INDUSTRY G.P.O.	
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Nicholas DeFelippo			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Antoni unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II	17. INFORMANT son Ronald I. DeFelippo		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 25, 1987, to April 1, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.)					
22b. SIGNATURE Roy W. Chesnut, M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-2-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROY W. CHESNUT, M.D.		22e. ADDRESS VA Medical Center, Perry Point, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 6, 1987	23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia
24. FUNERAL DIRECTOR Francis J. Collins, Jr. 500 University Blvd. West, Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR APR - 9 1987		25. REGISTRAR'S SIGNATURE Julia Benson-Rodgers	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies, pages 1 and 2 should be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert this page in the papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate completed.

# STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Arthur Dorsey</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>April 17, 1987</b>		2b. HOUR <b>5:40P M</b>	
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 4 08</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b>		IF UNDER 1 YEAR MONTHS DAYS <b>RS</b>		IF UNDER 24 HRS HOURS MIN. <b>MD</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>HARFORD COUNTY</b>		10. CITY OR TOWN OF DEATH <b>Perry Point, Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA Medical Center</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Unknown</b>		12b. KIND OF BUSINESS OR INDUSTRY		13. STREET ADDRESS / ZIP CODE <b>2798 The Alameda</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Dorsey</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clare Dillon</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes WW1</b>	
17. INFORMANT <b>Theodore Dorsey</b>		18. SOCIAL SECURITY NO. <b>215 30 6358A</b>		19. ADDRESS <b>2798 The Alameda</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma of lungs</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 9</b> , 19 <b>87</b> , to <b>April 17</b> , 19 <b>87</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 17</b> , 19 <b>87</b> , and that in <b>XXX</b> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.					
22b. SIGNATURE <b>MELECIA SANTOS, M.D.</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>4-20-87</b>	
22d. ADDRESS <b>VA Medical Center, Perry Point, Md.</b>		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4-23-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Garrison Forest</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>March Funeral Home, Baltimore, Md.</b>			
25a. DATE REC'D. BY REGISTRAR <b>APR 22 1987</b>		25b. REGISTRAR'S SIGNATURE <b>John Anderson-Kendall</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the funeral director. Page 4 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the funeral director. Page 5 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the funeral director. Page 6 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the funeral director. Page 7 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the funeral director. Page 8 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the funeral director. Page 9 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the funeral director. Page 10 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the funeral director. Page 11 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the funeral director. Page 12 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the funeral director. Page 13 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the funeral director. Page 14 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the funeral director. Page 15 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the funeral director. Page 16 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the funeral director. Page 17 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the funeral director. Page 18 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the funeral director. Page 19 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the funeral director. Page 20 should be detached for use as the burial-transit permit. 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Then please remove this certificate from the file and return it to the funeral director. Page 27 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the funeral director. Page 28 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the funeral director. Page 29 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the funeral director. Page 30 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the funeral director. Page 31 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the funeral director. Page 32 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the funeral director. Page 33 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the funeral director. Page 34 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the funeral director. Page 35 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the funeral director. Page 36 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the funeral director. Page 37 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the funeral director. Page 38 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the funeral director. Page 39 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the funeral director. Page 40 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the funeral director. Page 41 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the funeral director. Page 42 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the funeral director. Page 43 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the funeral director. Page 44 should be detached for use as the burial-transit permit. 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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 11270

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
Jenny Eggert			April 19, 87			11:30 PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Female	WH	April 04 1902	85			YRS. MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Poland	USA		Cecil MD.					
CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
RisingSun		Calvert Manor Nursing Home	Housewife					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. INSIDE CITY LIMITS?			13c. STREET ADDRESS / ZIP CODE		
Delaware New Castle Wilmington			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1222 Elm Street/19805 99999		
FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
Lean Lapkiewicz			Nellie Lukiewska					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
No			222-01-4885			Ethel Polecaro 66 Darien RD Newark DE 19711		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) <u>Respiratory Failure + Kidney Failure</u>								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								
(b) <u>Metastatic carcinoma from Bladder cancer</u>								
DUE TO, OR AS A CONSEQUENCE OF								
(c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
			P.M. 19					
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from <u>10/1/87</u> 19 <u>85</u> , to <u>4/19</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>3/31</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE						DEGREE		22c. DATE SIGNED
<u>James L. Dearworth</u>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		4/20/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS		
James Dearworth, MD						167 W Main St Newark DE 19711		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial			4/21/87		St. John's Cem.		Newark, New Castle, Del.	
24. FUNERAL DIRECTOR						25a. DATE RECD BY REGISTRAR		
R.T. Jones <u>Robert T. Jones</u>						APR 23 1987 <u>Julia London-Randall</u>		



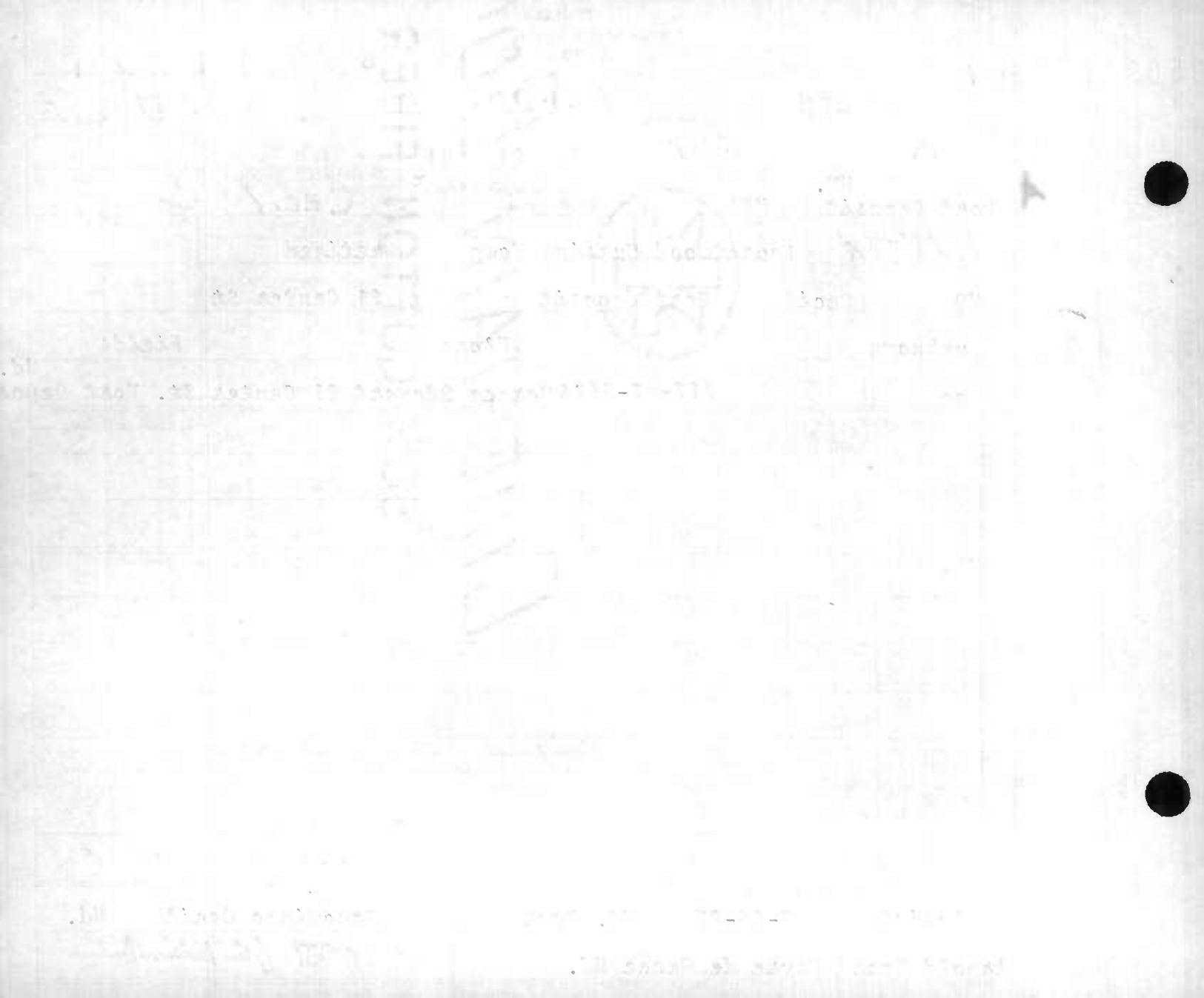
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10. John's Ave. New York, New Castle, Del.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR 1 - STATE REGISTRAR		8 7 REG. NO. 1 1 2 7 1	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST <b>JOSEPH FIELDS</b>		MONTH DAY YEAR <b>3 15 87</b>	
3. SEX <b>M</b>		4. RACE <b>BLACK</b>	
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
MONTH DAY YEAR <b>8 28 04</b>		<b>82 YS -</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	
<b>MD. Port Deposit</b>		<b>USA</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
		<b>Cecil Co MD.</b>	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION	
<b>EIKTON</b>		<b>Laurelwood Nursing Home</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
<b>retired</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			
13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e. STREET ADDRESS / ZIP CODE			
<b>MD Cecil Port Deposit YES NO 21 Center St 21904</b>			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
FIRST MIDDLE LAST <b>unknown</b>		FIRST MIDDLE LAST <b>Flora Fields</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
<b>no</b>		<b>717-07-5536</b>	
17. INFORMANT		ADDRESS	
<b>Horace Stewart</b>		<b>21 Center St. Port Depos Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia -</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cardio-pulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pulmonary Congestion &amp; edema -</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY	
		HOUR A.M. MONTH DAY YEAR <b>19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED	
		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
		STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>July</b> 19 <b>81</b> , to <b>3/15/87</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>3/14/87</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE		DEGREE	
<b>Gyanantilal K. Patel</b>		<b>MD</b>	
22c. DATE SIGNED		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
<b>3/17/87</b>			
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS	
<b>GATANTILAL K. PATEL MD</b>		<b>123 Singlerly Ave, Eikton MD 21921</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
<b>burial</b>		<b>3-20-87</b>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
<b>Mt. Zoar</b>		<b>Conowingo Cecil Md.</b>	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR	
NAME ADDRESS <b>Arnold Beard Havre de Grace Md.</b>		<b>APR 16 1987</b>	
25b. REGISTRAR'S SIGNATURE			
<b>Julia Gordon-Randall</b>			



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DHMH - 16 60M 7/B4  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. It can only be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Ida Frederick Fleming</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>4/5/87</i>					2b. YOUR AGE <i>110 3/4</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>9 23 17</i>			6. AGE (IN YEARS LAST BIRTHDAY) <i>69</i> YRS			7. UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington, D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil Co</i> MD.				
10. CITY OR TOWN OF DEATH <i>EIKTON</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Union Hosp.</i>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>			12b. KIND OF BUSINESS OR INDUSTRY	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <i>Md.</i>		13b. COUNTY <i>Cecil</i>		13c. CITY OR TOWN <i>North East</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>65 Bay Court Drive 21901</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Conrad Friedrich</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Augusta</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>073-09-2933</i>		17. INFORMANT ADDRESS <i>Ms. Janet Sisson 7524 Ambergate Place McLean, Va.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCVD.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>pericardial ulcer.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from <i>9/9</i> , 19 <i>81</i> , to <i>4/5/87</i> , 19 <i>87</i> , that (1) (we) last saw the deceased alive on <i>4/5/87</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Jui Chih Hsu</i>				DEGREE				22c. DATE SIGNED <i>4/6/87</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Jui Chih Hsu</i>				22e. ADDRESS <i>223 west main st. ea Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>		23b. DATE <i>4-6-87</i>		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <i>State Anatomy Board</i>				ADDRESS <i>Balto., Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>APR 09 1987</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Tindem-Randall</i>	

DHMH - 16 60M 7/B4  
(VRA 15, 4)

APR 09 1987

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. Page 5 should be filed with the State Dept. of Health and Mental Hygiene within 24 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
REG. NO. 11273									
1. DECEASED NAME (TYPE OR PRINT) Virginia L. Ford					2a. DATE OF DEATH MONTH DAY YEAR HOUR April 23 1987 3 PM				
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct 20 1945		6 AGE (IN YEARS LAST BIRTHDAY) 41 YRS		7b. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.			
10. CITY OR TOWN OF DEATH Perryville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 113 John Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) L.P. Nurse		12b. KIND OF BUSINESS OR INDUSTRY Hospital	
13a. STATE Maryland					13b. CITY OR TOWN Cecil		13c. STREET ADDRESS / ZIP CODE 113 John Street 21903		
14. FATHER'S NAME FIRST MIDDLE LAST Robert M. Truitt, Sr.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Doris Jones				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219 44 6098		17. INFORMANT ADDRESS Edwin E. Ford, Jr., 113 John St., Perryville, Md. 21903					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ADVANCED COLON CANCER</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>10-31-</u> 19 <u>85</u> , to <u>2-25</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>2-25</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Yogesh A. Patel</u>					DEGREE		22c. DATE SIGNED <u>4/29/87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Yogish A. Patel, M.D.					22e. ADDRESS 138 Cathedral St., Elkton, Md. 21921				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/25/87		23c. NAME OF CEMETERY OR CREMATORY Cherry Hill Methodist		23d. LOCATION CITY OR TOWN COUNTY STATE Cherry Hill Cecil Md.			
24. FUNERAL DIRECTOR <u>Ralph E. Hicks</u> Hicks Home For Funerals, Elkton, Md.					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>		

FROM COLLECTION BIER

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 11274

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
August Dominic K Gallo		4/17/87		0936 M	
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Male	White	Jan. 28, 1911	76 YRS.	MONTHS DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
Germany	U.S.A.		Cecil MD.		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b KIND OF BUSINESS OR INDUSTRY		
Elkton	Union Hospital	Taylor	Self-employed		
13a. CITY OR TOWN	13b. INSIDE CITY LIMITS?	13c. STREET ADDRESS / ZIP CODE			
Pa.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	914 Chester Pike 19079			
FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
John Gallo		Unknown			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT			
No	176-20-0561	914 Chester Pike Teresa Gallo Sharon Hill, Pa. 19079			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>4-16</u> 19 <u>87</u> to <u>4-17</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>4/16</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Ehsanur Rahman</u> MD		22c. DATE SIGNED <u>4/18/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>EHSANUR RAHMAN</u>		22e. ADDRESS <u>4745 STANTON - OGLETOWN ROAD.</u> <u>SUITE 131, NEWARK, DE 19713.</u>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial	4-21-87	Immaculate Heart		Linwood Delaware Pa.	
24 FUNERAL DIRECTOR NAME		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Such Funeral Home North East, Md.		APR 21 1987		Julia Davidson-Randall	





HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 could be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 will be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1 DECEASED NAME FIRST MIDDLE LAST LEE E. GEORGE						2a DATE OF DEATH MONTH DAY YEAR 4-25-87		2b HOUR pm 9:10 M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Nov 11 1923		6 AGE (IN YEARS LAST BIRTHDAY) 63		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.			
10 CITY OR TOWN OF DEATH Perry Point Md.		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b KIND OF BUSINESS OR INDUSTRY Auto	
13a STATE Virginia		13b COUNTY Fairfax		13c CITY OR TOWN Alexandria		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 2725 Fort Drive 22303	
14 FATHER'S NAME FIRST MIDDLE LAST Edward C. George				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mrytle E. Frazier					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. WWII		17 INFORMANT ADDRESS 493-18-3261 Debra George 2725 Fort Drive Alex., Va.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
MEDICAL CERTIFICATION									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>4-22</u> , 19 <u>87</u> , to <u>4-25</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Kevin M. Miller MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c DATE SIGNED 4/25/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) KEVIN MILLER M.D.				22e ADDRESS VA MEDICAL CENTER PERRY POINT MD.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE 4/29/87		23c NAME OF CEMETERY OR CREMATORY Lees		23d LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.			
24 FUNERAL DIRECTOR'S NAME CUNNINGHAM FUNERAL HOME				ADDRESS Cameron & Alfred St. Alex., Va.		25 DATE REC'D. BY REGISTRAR MAY 4 - 1987			
				25b REGISTRAR'S SIGNATURE Julia Anderson-Randall					

12/12/12 X

12/12/12 X

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The placid should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 11276

1. DECEASED NAME (TYPE OR PRINT) <u>William H HARRIS</u>			2a. DATE OF DEATH MONTH <u>4</u> DAY <u>17</u> YEAR <u>1987</u>		2b. HOUR <u>1902M</u>
3. SEX <u>MALE</u>	4. RACE <u>NEGRO</u>	5. DATE OF BIRTH MONTH <u>9</u> DAY <u>15</u> YEAR <u>12</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>74</u> YRS.	IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>USA MARYLAND</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <u>Cecil Co</u> MD.		
10. CITY OR TOWN OF DEATH <u>ELKTON</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>UNION HOSPITAL OF CECIL COUNTY</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>BUS DRIVER</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>PUBLIC SCHOOL</u>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MARYLAND</u> 13b. COUNTY <u>CECIL</u> 13c. CITY OR TOWN <u>WARWICK</u>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>3 MUMSEY ROAD 21912</u>
14. FATHER'S NAME FIRST <u>OTIS</u> MIDDLE <u></u> LAST <u>HARRIS</u>		15. MOTHER'S MAIDEN NAME FIRST <u>DANIE</u> MIDDLE <u></u> LAST <u>BROWN</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u> (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. <u>218-14-9642</u>		17. INFORMANT <u>ELSIE HARRIS</u> ADDRESS <u>3 MUMSEY RD. WARWICK, MARYLAND</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u></u> P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the undersigned) attended the deceased from <u>15 Jan</u> 19 <u>87</u> , to <u>Apr 17</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>Apr 17</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Wallace Obenshain MD</u>		DEGREE <u></u>		22c. DATE SIGNED <u>17 Apr 87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Wallace Obenshain, MD</u>		22e. ADDRESS <u>Main St Cecilton, Md. 21913</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	23b. DATE <u>April 25, 1987</u>	23c. NAME OF CEMETERY OR CREMATORY <u>UNION BETHEL CEM.</u>		23d. LOCATION CITY OR TOWN <u>CECILTON</u> COUNTY <u>CECIL</u> STATE <u>MARYLAND</u>	
24. FUNERAL DIRECTOR NAME <u>Lee Funeral Home 259 E. Main St Elkton</u>		25a. DATE REC'D. BY REGISTRAR <u>APR 27 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Friedman-Pinder</u>	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8711271

1. DECEASED NAME (TYPE OR PRINT) <b>CHARLES E HENSON</b>		2a. DATE OF DEATH MONTH <b>4</b> DAY <b>23</b> YEAR <b>87</b>		2b. HOUR <b>13:00 PM</b>
3. SEX <b>M</b>	4. RACE <b>C I</b>	5. DATE OF BIRTH MONTH <b>7</b> DAY <b>25</b> YEAR <b>1918</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70 yrs</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil Co</b> MD.
10. CITY OR TOWN OF DEATH <b>Elkton</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Hospital Cecil County, Elkton</b>		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <b>YARDMAN</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>AMERICAN HOME &amp; HARDWARE</b>
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Cecil</b>	13c. CITY OR TOWN <b>Elkton</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>12 Kent Road 21921</b>
14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b>-</b> LAST <b>HENSON (d)</b>		15. MOTHER'S MAIDEN NAME FIRST <b>ANNIE</b> MIDDLE <b>-</b> LAST <b>Hollingsworth (d)</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>1944-4/1246 212-16-7451</b>		17. INFORMANT <b>GAIL L. BRYANT (daughter)</b> ADDRESS <b>321 St. John St. Havre de Grace, MD.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Leiomyosarcoma of Colon -</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>with Metastasis -</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Renal failure -</b>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <b>7/15/83</b> , 19____, to <b>4/23/87</b> , 19____, that (I) (we) last saw the deceased alive on <b>4/23/87</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Jayantilal K. Patel</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>4/23/87</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAYANTILAL K PATEL MD</b>		22e. ADDRESS <b>123 SINGERLY AVE, ELKTON MD 21921</b>		
23a. BURIAL, CREMATION, REMOVAL (TYPE)		23b. DATE <b>April 28, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BOHEMIA MANOR</b>
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Chesapeake City MD</b>		23e. DATE REC'D. BY REGISTRAR <b>APR 28 1987</b>		
24. FUNERAL DIRECTOR NAME <b>Charles W. Gray</b> ADDRESS <b>201 N. GRAY AVE, WILM, DE. 19805</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This permit may be carbon-papered. Pages 1 and 2 should be filed with page 3 after death with the State Dept. of Health and Mental Hygiene prior to interment, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 11278

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
ALPHONSO		HOLT JR.		April 1, 1987		1:10pm	
3. SEX	4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
MALE	BLACK		7 26 1923		63 YRS.		
7a. BIRTHPLACE (COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
GEORGIA	U. S. A.				PERRY POINT, MARYLAND		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Perry Point, Md.	VA Medical Center		PROPRIETOR		GROCERY STORE		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
13a. STATE		13b. COUNTY		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		MARYLAND 21207	
MARYLAND		BALTIMORE				2633 PURNELL DRIVE-- BALTIMORE.	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]		16b. SOCIAL SECURITY NO.	
ALPHONSO		LILLIE MAE GLOUCESTER		YES <input type="checkbox"/> NO <input type="checkbox"/> WW II		253-24-5082	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Acute, chronic renal failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diabetes mellitus; Anemia; Hypertensive vascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ISABELLE M. HOLT							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from March 9, 1987, to April 1, 1987.		22b. SIGNATURE DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-1-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
JOHN DONERGAN, M.D.		VA Medical Center, Perry Point, Md.		BURIAL		4/08/1987	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR'S NAME		25a. DATE REC'D. BY REGISTRAR	
GARRISON FOREST VETERAN		BALTIMORE, MARYLAND		2501 Gwynns Falls Pkwy. Baltimore, Md. 21216		APR - 6 1987	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE		25e. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return pages 1 and 2 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 11279

1. DECEASED NAME (TYPE OR PRINT) <b>Margaret A. Howard</b>		2a. DATE OF DEATH MONTH <b>April</b> DAY <b>22</b> YEAR <b>1987</b>		2b. HOUR <b>6:40A</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>May</b> DAY <b>3</b> YEAR <b>1920</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil County</b> MD.		10. CITY OR TOWN OF DEATH <b>Elkton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Hospital</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE <b>326 Maloney Road 21921</b>	
13b. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>Cecil</b> 13c. CITY OR TOWN <b>Elkton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>326 Maloney Road 21921</b>	
14. FATHER'S NAME FIRST <b>Benjamin</b> MIDDLE <b>Preston</b> LAST <b>Glady's</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Gladys</b> MIDDLE <b>Humes</b> LAST <b>Humes</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES)	
16b. SOCIAL SECURITY NO. <b>222-05-4844</b>		17. INFORMANT <b>Mrs. Frances Fish</b>		ADDRESS <b>405 Cecil St. Chesapeake City</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **CARCINOMA OF THE OVARY**

DUE TO, OR AS A CONSEQUENCE OF

(b) **CARCINOMA OF THE OVARY**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>4-9</b> , 19 <b>87</b> , to <b>4-23</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>4-22</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Glenn M. McKean</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4-24-87</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Glenn M. McKean</b>		22e. ADDRESS <b>259 E. MAIN ST. ELKTON MD.</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>April 25, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cherry Hill Meth.</b>		23d. LOCATION CITY OR TOWN <b>Cherry Hill</b> COUNTY <b>Cecil</b> STATE <b>Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Gee Funeral Home</b> ADDRESS <b>259 E. MAIN ST. ELKTON MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 27 1987</b>		25b. REGISTRAR'S SIGNATURE <i>Linne Anderson-Rudolph</i>			

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52132 MAY -

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

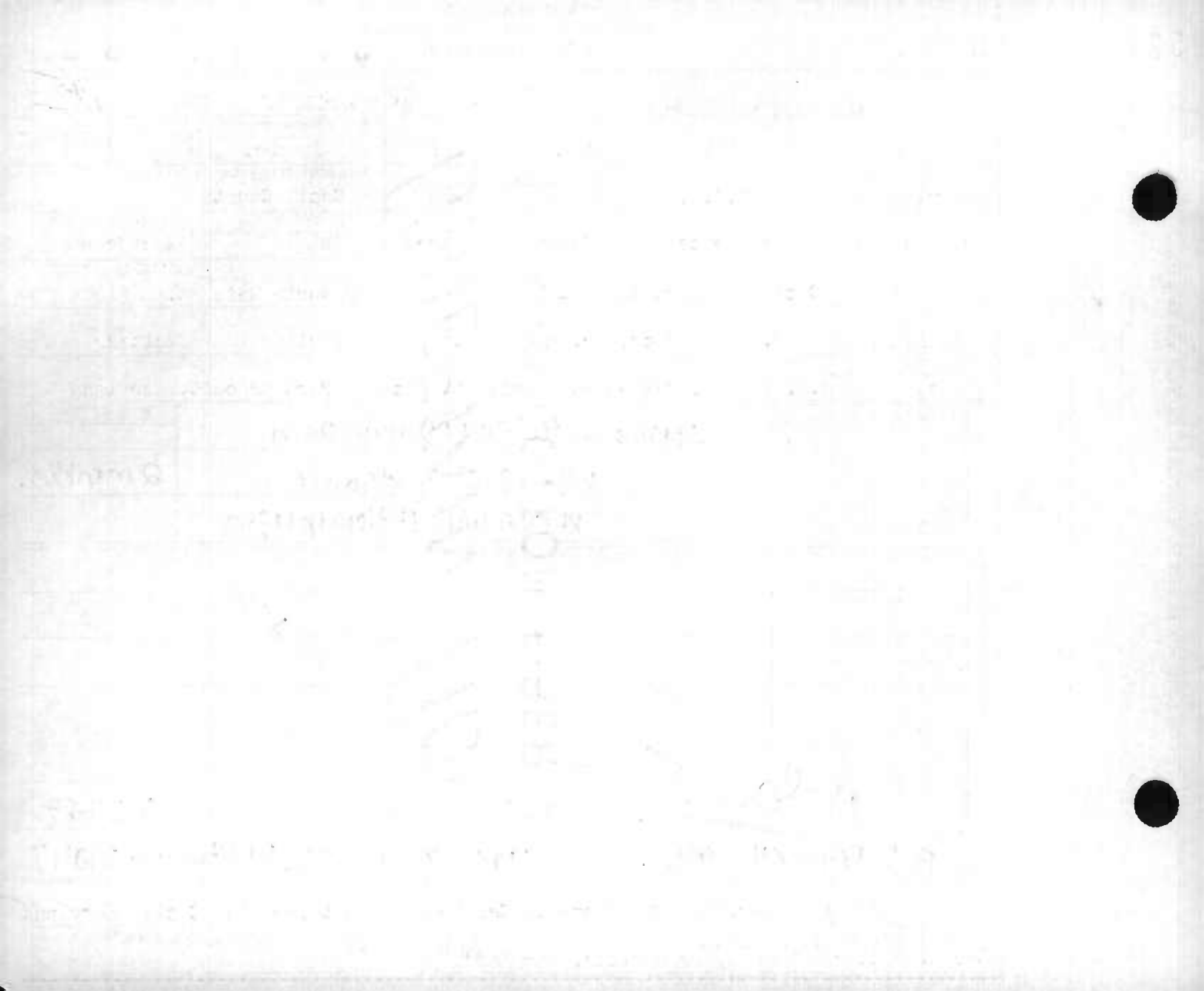
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director's office. It should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director. Pages 3 and 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified above.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 11280

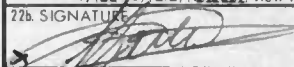
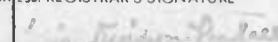
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM H. JACK JR			2a. DATE OF DEATH MONTH DAY YEAR April 23 1987			2b. HOURS MIN 1:45 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 2 1925		6. AGE (IN YEARS LAST BIRTHDAY) 61 yrs. YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.			
10. CITY OR TOWN OF DEATH Port Deposit		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Residence: 160 North Main Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BRL		12b. KIND OF BUSINESS OR INDUSTRY Aberdeen	
13a. STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Port Deposit		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 160 North Main St. 21904	
14. FATHER'S NAME FIRST MIDDLE LAST William H. Jack, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pauline Smeltzer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II		17. INFORMANT ADDRESS Emily M. Jack Port Deposit, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous cell CA. (Rt) main stem DUE TO, OR AS A CONSEQUENCE OF (b) with SVC syndrome. DUE TO, OR AS A CONSEQUENCE OF (c) R. CVA with Lt Hemiplegia								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE B. D. PAREKH				DEGREE MD. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4-24-87.	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. D. PAREKH MD.				22e. ADDRESS 1908 HARFORD RD. Fallston MD. 21047					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 27, 1987		23c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Port Deposit Cecil Maryland			
24. FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Maryland				25. DATE OF REGISTRATION BY REGISTRAR APR 29 1987					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) <b>KEYES, John Stanford Keyes</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>April 18, 1987</b>			2b. HOUR <b>7:25P M</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 3 1927</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Connecticut</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil County MD</b>			
10. CITY OR TOWN OF DEATH <b>Perry Point</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Perry Point V.A. Medical Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Sgt.</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Harford</b>		13c. CITY OR TOWN <b>Aberdeen</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>651 Brenda Lane, Aberdeen, MD 21001</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry Joseph Keyes</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Virginia Rose Stanford</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Korea 045 18 9847</b>		17. INFORMANT ADDRESS <b>Maria Keyes 651 Brenda Lane Aberdeen, Maryland 21001</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I, this hospital) attended the deceased from <b>XXXXX Jan 9, 1985</b> , to <b>April 18, 1987</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>April 18, 1987</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (could not) view the body after death.									
22b. SIGNATURE 				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>4/18/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jean R. Bastien, M.D.</b>				22e. ADDRESS <b>VA Medical Center, Perry Point, MD 21902</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>4-20-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>R. A. Ferris &amp; Co.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>West Chester Chester PA</b>			
24. FUNERAL DIRECTOR NAME <b>Tarring Funeral Home, P.A.</b>				ADDRESS <b>333 S. Parke St Aberdeen, MD 21001</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 22 1987</b>		25b. REGISTRAR'S SIGNATURE 	

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or filed, it shows any injury, or other traumatic event, the medical examiner must be notified of one.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR			
JOHN E. LEWANDOWSKI			April 18, 1987			4:00pm			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male		White		February 4, 1922		65		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Phila., Pa.		USA				Cecil County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Perry Point, Md.		VA Medical Center				Machine Operator		Textile	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Md.		Baltimore		Essex		13e. STREET ADDRESS / ZIP CODE			
						758 Mansfield Rd. 21221			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
Frank Joseph Lewandowski				Mary Tozdyowski					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS	
Yes				WWII		165-14-9286		Dorothy Maykantz, Sister Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Cardiomegaly, massive</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Edema &amp; congestion of lungs, severe</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Bronchopneumonia, acute &amp; organizing, bilateral</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
		HOUR A.M. MONTH DAY YEAR		P.M.		19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>April 15</u> , 19 <u>87</u> , to <u>April 18</u> , 19 <u>87</u> . <del>XXXXXX</del>									
And that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				4-20-87	
Avelina Hernandez, M.D.				VA Medical Center, Perry Point, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. DATE REC'D BY REGISTRAR	
Burial		4/24/87		Md. Veterans Cemetery		Crownsville, Md.		APR 23 1987	
24. FUNERAL DIRECTOR		1407 Old Eastern Ave		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Bruzdzinski Funeral Home, Essex, Md. 21221						Julia Davidson-Randall			

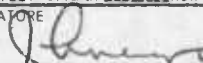
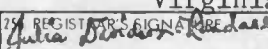




STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

REG. NO. 1 1 2 8 5

1. DECEASED NAME (TYPE OR PRINT) <b>Hugh David Murdock</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>April 16, 1987</b>		7b. HOUR <b>10:39PM</b>	
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>February 20, 1920</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Mississippi</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Perry Point, Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA Medical Center</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Postal Ser.</b>			
13a. STATE <b>Virginia</b>		13b. COUNTY <b>Richmond</b>		13c. CITY OR TOWN <b>Richmond</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Judah Murdock</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Madie Sally Gardner</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>	
17. INFORMANT <b>Hugh D. Murdock, Jr.</b>		18. SOCIAL SECURITY NO. <b>231 32 0641</b>		19. ADDRESS <b>301 G. St. S.W. Washington, D. C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Aspiration pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetic ketoacidosis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 1, 1986</b> to <b>April 16, 1987</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>April 16, 1987</b> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (we) did not view the body after death.					
27b. SIGNATURE 		DEGREE <b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input checked="" type="checkbox"/>		27c. DATE SIGNED <b>4-17-87</b>	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN LONERGAN, M.D.</b>		27e. ADDRESS <b>VA Medical Center, Perry Point, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>04/21/1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodland Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Richmond Virginia</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Watkins Funeral Home, Richmond, VA.</b>			
25a. DATE REC'D. BY REGISTRAR <b>MAY 07 1987</b>		25b. REGISTRAR'S SIGNATURE 			



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**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **11 284**

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2. DATE KNOWN OF DEATH		3. MONTH		4. DAY		5. YEAR		6. HOUR	
HATTIE L. MUSSER								4		23		19		87			
7. SEX	8. RACE	9. DATE OF BIRTH		10. AGE (IN YEARS)		11. IF UNDER 1 YR.		12. IF UNDER 24 HRS.		13. DATE PRONOUNCED DEAD		14. MONTH		15. DAY		16. YEAR	
Female	White	6-5-1918		68 YRS.						4		23		19		87	
17. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		18. CITIZEN OF WHAT COUNTRY?		19. MARRIED		20. NEVER MARRIED		21. WIDOWED		22. DIVORCED		23. BALTIMORE CITY OR COUNTY OF DEATH		24. MD.			
Pa.		U.S.A.		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		Cecil County					
25. CITY OR TOWN OF DEATH		26. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		27. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		28. KIND OF BUSINESS OR INDUSTRY		29. HOME		30. HOME							
Elkton		Union Hospital		Homemaker		Home											
31. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		32. STATE		33. COUNTY		34. CITY OR TOWN		35. INSIDE CITY LIMITS?		36. STREET ADDRESS		37. YES		38. NO		39. 91 Edgewater Ave. 21914	
Md.		Cecil		Charlestown				<input checked="" type="checkbox"/>									
40. FATHER'S NAME		41. MOTHER'S MAIDEN NAME		42. FIRST		43. MIDDLE		44. LAST		45. FIRST		46. MIDDLE		47. LAST		48. 20 E. Clairmont Dr. Newark, Del. 19702	
Frank Wickwire		Unknown															
49. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		50. SOCIAL SECURITY NO.		51. INFORMANT		52. ADDRESS		53. CITY		54. STATE		55. ZIP		56. DATE		57. YEAR	
No		235-34-6173		Willard Kisner		Newark, Del.		19702									

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Multiple injuries</u>			
DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.			
(b) _____			
DUE TO, OR AS A CONSEQUENCE OF			
(c) _____			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY	
		HOUR <u>6:49</u> M. MONTH <u>4</u> DAY <u>23</u> YEAR <u>1987</u>	
21c. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
		road	
21e. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21f. LOCATION	
Passenger of pick-up truck/van collision.		STREET	
		CITY OR TOWN	
		Cecil	
		STATE	
		MD	
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:		22b. TITLE (SPECIFY)	
Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Deputy Chief	
ACTUAL SIGNATURE		DATE SIGNED	
Ann M. Dixon, M.D.		4-24-87	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS	
		111 Penn St., Balto., MD 21201	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. COUNTY		23f. STATE	
Burial		4-27-87		Cherry Hill Cemetery		Cherry Hill		Cecil		Md.	
24. FUNERAL HOME		24a. NAME		24b. ADDRESS		24c. DATE REC'D. BY REGISTRAR		24d. REGISTRAR'S SIGNATURE		24e. DATE	
Funeral Home North East, Md.						APR 28 1987		Julia Davidson-Randall			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO THE

SECRETARY OF THE  
NAVY  
WASHINGTON, D. C.

11



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Their office must have carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 11285

1 - FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT)		2b. DATE OF DEATH MONTH DAY YEAR		2c. HOUR	
		Lois Rebecca Nafzinger		April 18, 1987		4:25am	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		Cauc		June 19, 1901		85 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
Ohio		USA				Cecil MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Elkton		Union Hospital		Homemaker			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MD		Cecil		Cecilton		Earlton Village	
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
John William Krabill		Florence Bosserman		N/A		214-34-8572	
17 INFORMANT ADDRESS		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____		17a. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		17b. KIND OF BUSINESS OR INDUSTRY	
John Nafzinger Crumpton		Re-infarction major coronary artery		Union Hospital		Homemaker	
		DUE TO, OR AS A CONSEQUENCE OF (b) _____				4-5myrs	
		DUE TO, OR AS A CONSEQUENCE OF (c) _____					
		PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
		Previous severe cardiogenic shock and renal failure					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the undersigned) attended the deceased from _____ Mar 1, 19 87, to _____ 18 Apr 19 87, that (I) (we) last saw the deceased alive on _____ 18 Apr 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE DEGREE		22c. DATE SIGNED			
Wallace Obenshain MD				19 Apr 87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Wallace Obenshain, N.D.		Cecilton, Md. 21913		Burial		4/22/87	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		24 FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	
Fork M.E. Cemetery		Fork Baltimore MD		Fellows Funeral Home Box 270 Millington		APR 24 1987	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE					
J. J. Anderson-Randall							

1

April 10, 1987 4:25pm

John Watson

82

June 12, 1981

Ohio

Ohio

Geoff

USA

Ohio

Washington

Union Hospital

Ohio

Washington Village

2

Geoff

Geoff

Ohio

Washington

Washington

John Watson

John Watson

USA

Ohio

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove corrector fluid from lines 1 and 2 and fill in burial date within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. A medical examiner's signature must be on page 4 of this certificate. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, a medical examiner's signature must be on page 4 of this certificate.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		87 REG. NO. 111286							
1. DECEASED NAME (TYPE OR PRINT) Fred W. Oeckel				2a. DATE OF DEATH MONTH DAY YEAR April 28, 1987		2b. HOUR 9:25P M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 25 1894		6. AGE (IN YEARS (LAST BIRTHDAY)) 92 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Newark, New Jersey		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.			
10. CITY OR TOWN OF DEATH Perryville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Perry's Point Veterans Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Commercial Fisherman		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Delaware		13b. COUNTY Sussex		13c. CITY OR TOWN Lewes		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 502 Pilottown Road 19958	
14. FATHER'S NAME FIRST MIDDLE LAST Frederick Oeckel				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Schoenaveiss					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 151 18 6680		17. INFORMANT ADDRESS VAMC, Perry Point, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF <u>Senile Dementia - Alzheimer's type</u> (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from <u>3-17-19-87</u> to <u>4-28-19-87</u> , that <u>X</u> (we) last saw the deceased alive on <u>4-28-19-87</u> , and that in <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, <u>(we)</u> (did) (did not) view the body after death.									
22b. SIGNATURE <u>Prem Lal, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 4-28-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PREM LAL, M.D.				22e. ADDRESS VAMC, Perry Point, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 2, 1987		23c. NAME OF CEMETERY OR CREMATORY Lewes Presbyterian Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Lewes Sussex Delaware			
24. FUNERAL DIRECTOR NAME Parsell, Atkins & Lodge				ADDRESS 119 W 4th St, Lewes, DE		25a. DATE REC'D. BY REGISTRAR MAY 5 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



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050402 APR 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 11287

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
NOEL FRANCIS PARRISH								April 7, 1987					12:34pm	
3 SEX		4. RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS				
MALE		CAUCASIAN		NOVEMBER 11, 1909		77 YRS		MONTHS		DAYS		HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH								
KENTUCKY		USA				CECIL						MD.		
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
Perry Point, Md.		VA Medical Center		OFFICER		MILITARY								
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS / ZIP CODE						
VIRGINIA		NONE		ALEXANDRIA		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4701 KENMORE AVE/1310				(22304)		
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME												
GARLAND		JOSEPH		PARRISH		LUCY		LOUISA		LAMBERT				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT		ADDRESS								
YES		1935-1964		460-64-1967		FLORENCE PARRISH		4701 KENMORE AVE ALEXANDRIA						

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest			
DUE TO, OR AS A CONSEQUENCE OF (b) Bronchopneumonia, acute, severe, bilateral w/ abscess formation in lower lobes.			
DUE TO, OR AS A CONSEQUENCE OF (c) Aspiration of gastric contents into the tracheobronchial			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: tree. Senile dementia of the alzheimer type, nasal gastric tube, possible cancer of prostate.			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (X) (this hospital) attended the deceased from October 2, 1986, to April 7, 1987. I observed the deceased (and not view the body after death).			
22b. SIGNATURE <i>John Loneragan</i>		22c. DATE SIGNED 4-8-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN LONERGAN, M.D.		22e. ADDRESS VA Medical Center, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL	4/10/87	NATIONAL CEMETERY	ARLINGTON VIRGINIA
24 FUNERAL DIRECTOR NAME Demaime Funeral Home, Alexandria, VA.		25a. DATE REC'D. BY REGISTRAR APR 14 1987	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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050222 APR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) JAMES MURREL PHILLIPS			2a. DATE OF DEATH MONTH DAY YEAR 4 8 87			2b. HOUR 4:15 AM				
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Nov. 29 1911		6 AGE (IN YEARS LAST BIRTHDAY) 75		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alderson, W. Va.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Cecil Co. MD.				
10 CITY OR TOWN OF DEATH ELKTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Driver		12b. KIND OF BUSINESS OR INDUSTRY Trucking		
13a. STATE Md.			13b. COUNTY Cecil		13c. CITY OR TOWN North East		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 207 N. Main St. 21901	
14 FATHER'S NAME FIRST MIDDLE LAST James Mason Phillips					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sally Burton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 235-26-9660		17 INFORMANT Yvonne Phillips		ADDRESS 207 N. Main St. Ext. North East, Md. 21901			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic heart disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>3-4 days</u>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic obstructive pulmonary disease -</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>4/6</u> 19 <u>87</u> to <u>4/8</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>4/8</u> 19 <u>87</u> , and that in (my) <del>our</del> opinion death occurred on the (date and hour and from the causes stated above, (I) <del>we</del> (did) (did not) view the body after death.										
22b. SIGNATURE Edgar E. Folk Jr.			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/8/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDGAR E. FOLK JR.					22e. ADDRESS Union Hospital, ELKTON, MD. 21921					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-10-87		23c. NAME OF CEMETERY OR CREMATORY North East Meth.		23d. LOCATION CITY OR TOWN COUNTY STATE North East Cecil Md.			
24 FUNERAL DIRECTOR NAME Funeral Home North East, Md.						25a. DATE REC'D. BY REGISTRAR APR 14 1987		25b. REGISTRAR'S SIGNATURE A. J. Fisher-Lindner		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed at by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

4/15



X

12 21 + 12 0/4

12/15

12/15 - 6/15/12, x

12/15 - 6/15/12, x

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM G. PHILLIPS</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>APR 7 1987</b>		2b. HOUR <b>7:00 AM</b>
3. SEX <b>Male</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>4-1-07</b>	6. AGE (IN YEARS, LAST BIRTHDAY) <b>80 yrs</b>	7. UNDER 1 YEAR MONTHS DAYS <b>80</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Delaware</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>ecil County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Elkton</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lincoln Hospital</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mechanic</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>auto</b>	
13a. STATE <b>Delaware</b>	13b. CITY OF TOWN <b>N.C.</b>	13c. STREET ADDRESS <b>Box 7 - Wallace Rd</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME <b>William A. Phillips</b>	15. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Phillips</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	
17. SOCIAL SECURITY NO. <b>221-09-8526</b>		17. INFORMANT <b>John A. Phillips - Odesia Rd</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>arteriosclerotic coronary artery disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <b>4-1</b> , 19 <b>80</b> , to <b>4-7</b> , 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>4-7</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		
22b. SIGNATURE <b>Kenneth Lewis MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>4/7/87</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Kenneth Lewis MD</b>		22e. ADDRESS <b>12 Pennington St Middletown DE 19709</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>4/10/87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Old Drawyers Cem</b>	23d. LOCATION (CITY OR TOWN) COUNTY STATE <b>Odesia - N.C. - Del.</b>	24. FUNERAL DIRECTOR <b>Robert C. Dutcher - Middletown, Del.</b>
25a. DATE REC'D. BY REGISTRAR <b>APR 14 1987</b>		25b. REGISTRAR'S SIGNATURE <b>John R. Radwell</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Pages 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

4/15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Their place remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "Not Viewed," item 21b is required. If item 21 is marked as "Viewed," item 21b is not required.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8711290

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>JOHN HENRY PIEPER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>April 12, 1987</b>			2b. HOUR <b>6:05 PM</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 20, 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Elkton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Laurelwood Nursing Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Handyman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Landscapping</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Harford</b>		13c. CITY OR TOWN <b>Edgewood</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>2307 Shannon Road 21040</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Henry Pieper</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Roberta Thompson</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>218-09-9072</b>		17. INFORMANT ADDRESS <b>Miss Geraldine Pieper, 2307 Shannon Road Edgewood, Md. 21040</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Benign Prostatic Hyperplasia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>COPD</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Andrew Nowakowski</b> M.D. DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4-13-87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Andrew Nowakowski, M.D.</b>						22e. ADDRESS <b>125 N. Main St., Bel Air, Md. 21014</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Apr. 15, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Spesutia Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Perryman Harford Md.</b>			
24. FUNERAL DIRECTOR <b>Howard K. McComas III, Abingdon, Md. 21009</b>						25a. DATE REC'D. BY REGISTRAR <b>APR 14 1987</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

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Handwritten text at the bottom left, possibly a date or signature.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial permit. Then please remove carbon papers and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		87 REG. NO. 11291							
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JAMES F. PRICE</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>April 6, 1987</b>				2b. HOUR <b>11:20pm</b>	
3. SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 5 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>77</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> MD.			
10. CITY OR TOWN OF DEATH <b>Perry Point, Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA Medical Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Military</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Harford</b>		13c. CITY OR TOWN <b>Aberdeen</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <b>635 Webb Street 21001</b>									
14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel Price</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Martha UNK</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>236-62-0780</b>		17. INFORMANT ADDRESS <b>Ilse M. Price 635 Webb Street Aberdeen, Maryland 21001</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Atherosclerotic cardiovascular disease</b>									
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebrovascular atherosclerosis</b>									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 30</b> , 19 <b>81</b> , to <b>April 6</b> , 19 <b>87</b> <b>xxxxxxx</b>									
and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Daniel Bouchette</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>4-6-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DANIEL BOUCHETTE, M.D.</b>				22e. ADDRESS <b>VAMC, Perry Point, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Apr. 9, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harford Mem. Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Aberdeen Harford MD</b>			
24. FUNERAL DIRECTOR <b>Tarring Funeral Home, Aberdeen, Md. 21001-3399</b>				25. DATE REC'D. BY REGISTRAR <b>APR 10 1987</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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10M FIBER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon pages 3 and 4 and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Reva K. Johnston Racine					2a. DATE OF DEATH MONTH DAY YEAR April 24, 1987			2b. HOUR 11:00 A.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan 2, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.				
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital of Cecil County				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland					13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louie C. Wimer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216 34 9395		17. INFORMANT ADDRESS Emma Lou Kline, 201 Park Circle, Elkton, Md. 21921						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cardiopulmonary Collapse</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction / CHF</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CAD</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes Hour		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>Brain metastases of Lung Cancer</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Dr. Robert Denitzio</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4/28/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Robert Denitzio, M. D.				22e. ADDRESS Route 213, Cecilton, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/28/87		23c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Elkton Cecil Md.				
24. FUNERAL DIRECTOR Hick's Home for Funerals				25a. DATE RECD. BY REGISTRAR APR 30 1987		25b. REGISTRAR'S SIGNATURE <u>James R. Radabaugh</u>				

MEDICAL CERTIFICATION

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATHFOR  
STATE  
REGISTRAR8 / REG. NO. 11253  
2a DATE OF DEATH MONTH DAY YEAR 4 3 87 6:30 AM1. DECEASED NAME FIRST MIDDLE LAST  
(TYPE OR PRINT) PEARL E REYNOLDS

3 SEX Female 4 RACE White 5 DATE OF BIRTH MONTH DAY YEAR JAN. 21, 1895

6 AGE (IN YEARS LAST BIRTHDAY) 92 IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware 7b CITIZEN OF WHAT COUNTRY? USA 8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.

10 CITY OR TOWN OF DEATH Rising Sun 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CALVERT Manor Nursing Home

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House-keeper 12b KIND OF BUSINESS OR INDUSTRY

13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE 13c CITY OR TOWN Delaware New Castle Wilmington

13d INSIDE CITY LIMITS? YES ☒ NO ☐ 13e STREET ADDRESS / ZIP CODE 4626 Griffin Drive 19808

14 FATHER'S NAME FIRST MIDDLE LAST Thomas GILSTON

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mollie

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO 16b SOCIAL SECURITY NO. 221 14 1575

17 INFORMANT ADDRESS 4626 Griffin Dr., Wilm., Del. 19808  
Marion T. Reynolds (Daughter-In-Law)18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), (c).  
PART 1. DEATH WAS CAUSED BY  
IMMEDIATE CAUSE (a) Cerebrovascular accident (stroke)  
DUE TO, OR AS A CONSEQUENCE OF  
(b) cerebrovascular disease  
DUE TO, OR AS A CONSEQUENCE OF  
(c) arteriosclerosis  
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a DATE OF OPERATION 19b CONDITION FOR WHICH OPERATION WAS PERFORMED 20a AUTOPSY? YES ☐ NO ☐ 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c HOW INJURY OCCURRED [ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2]21d INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☐ AT WORK 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f LOCATION STREET CITY OR TOWN COUNTY STATE

22a I certify that (I) (this hospital) attended the deceased from 1/26, 1978, to 4/3, 1987, that (I) (we) last saw the deceased alive on 3/3, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE James R. Deenworthe DEGREE ATTENDING PHYSICIAN MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ 22c DATE SIGNED 4/3/87

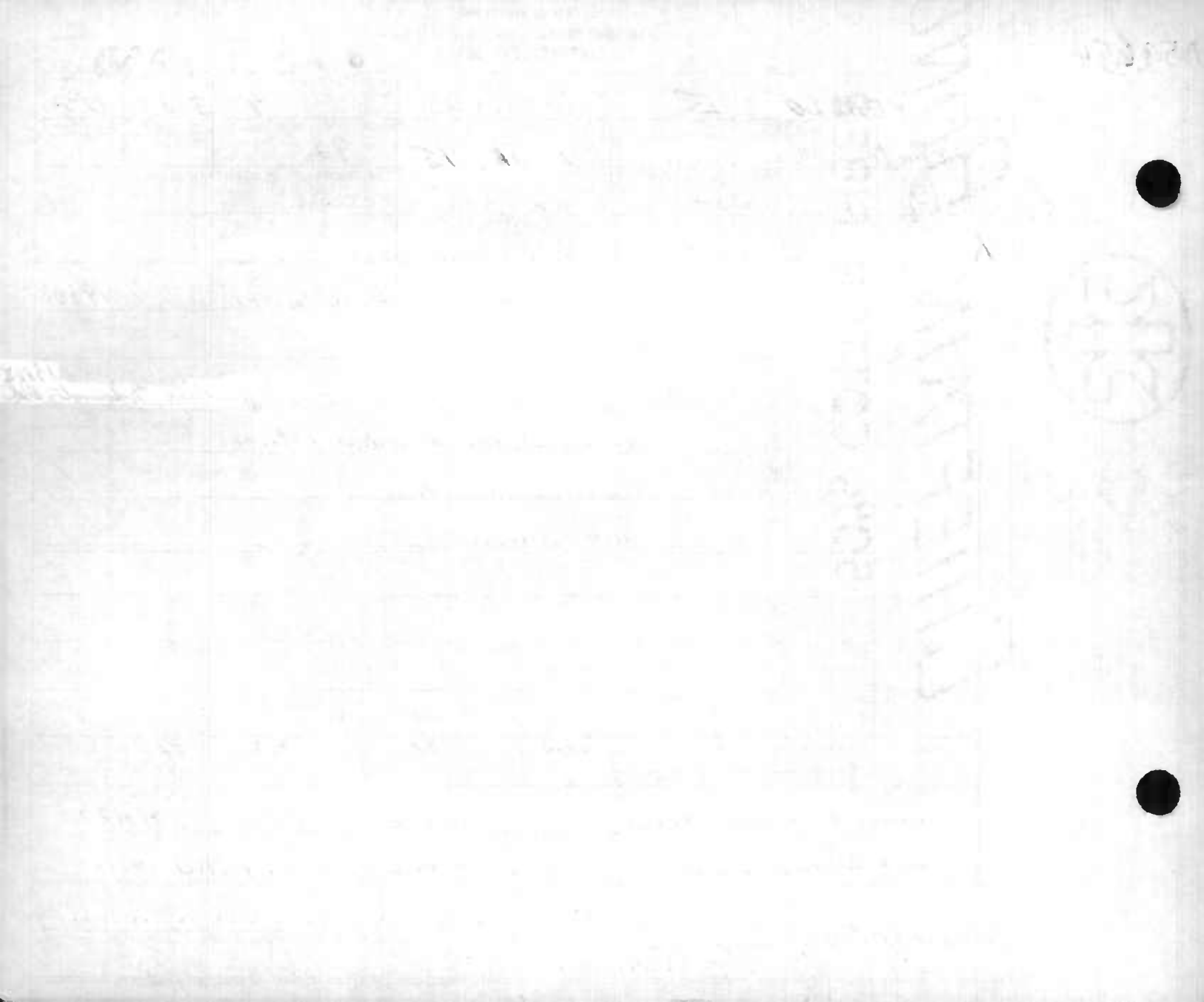
22d PHYSICIAN'S NAME (TYPE OR PRINT) James R. Deenworthe, M.D. 22e ADDRESS 167 W. Main St. Newark, Del. 19711

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b DATE 4/7/87 23c NAME OF CEMETERY OR CREMATORY Gracelawn Mem. Park 23d LOCATION CITY OR TOWN COUNTY STATE Wilmington, N. C., Del.

23e ADDRESS 23f DATE REC'D. BY REGISTRAR 23g REGISTRAR'S SIGNATURE 23h REGISTRAR'S SIGNATURE  
Albert P. McCrory, III 4/23/87TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

999999  
DHMH - 16 60M 7/84  
(VRA 15/4)



50061 APR 10 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send it to the funeral home. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		87 REG. NO. 11294							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Florence C. Sanderson</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>4/7/87</i>			2b. HOUR <i>800 A.M.</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>April 13 1910</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>76</i> YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil</i> MD.			
10. CITY OR TOWN OF DEATH <i>Elkton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Union Hospital of Cecil County</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Clerk</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>V.A.M.C., N.C.</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i> 13b. COUNTY <i>Harford</i> 13c. CITY OR TOWN <i>Havre de Grace</i>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>100 Revolution Street 21078</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles Brinkman</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Ryan</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>218-38-3875</i>		17. INFORMANT ADDRESS <i>Patsie P. Meck Perryville, Maryland</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIOVASCULAR ARREST</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b) <i>OVERWHELMING STRESS</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>UNKNOWN TOXIC INFECTION</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Minutes</i> <i>Days</i> <i>Days</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>PRIME PNEUMONIA SLO CVA MAINTAINED, HYPERTENSION</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>4/7</i> , 19 <i>87</i> , to <i>4/7</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>4/6</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>[Signature]</i>				DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>4/7/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Linwood Davis, MD</i>				22e. ADDRESS <i>721 Bridge St. Elkton, MD 21921</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Apr. 10, 1987</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Mark's Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Perryville Cecil Maryland</i>			
24. FUNERAL DIRECTOR NAME <i>Lee A. Patterson &amp; Son, Perryville, Maryland</i>				25a. DATE REC'D. BY REGISTRAR <i>APR - 9 1987</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

3

4/14



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it may be removed from the body and placed in the casket. It should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and place them in the casket with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the funeral director must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 11295

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPH PAUL SHEPARD		APRIL 11, 1987		9:50 P.M.	
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 03 08 30	6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.		
10. CITY OR TOWN OF DEATH RISING SUN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 764 Hopewell Road	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman	12b. KIND OF BUSINESS OR INDUSTRY Food		
13a. STATE Maryland		13b. COUNTY Cecil	13c. CITY OR TOWN Rising Sun	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Jessie L Shephard		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Farmer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. n/a		17. INFORMANT ADDRESS Mary L. Shephard 764 Hopewell Rd Rising Sun, MD 21911	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC SMALL CELL LUNG CANCER</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>18 mo</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>October</u> , 19 <u>85</u> , to <u>April 11</u> , 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>APRIL 7</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) not see the body after death.					
22b. SIGNATURE <u>Alexander Hantel</u>		DEGREE MD		22c. DATE SIGNED 4/13/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALEXANDER HANTAL MD		22e. ADDRESS 600 N. WHITE ST BALTIMORE MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-15-87		23c. NAME OF CEMETERY OR CREMATORY Conowingo Baptist	
23d. LOCATION CITY OR TOWN COUNTY STATE Cecil MD		24. FUNERAL DIRECTOR NAME ADDRESS R.T. Foard Funeral Home Rising Sun MD			
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE APR 21 1987 <u>Julia Tindon-Rubens</u>			

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APR 19 1964

APR 19 1964

APR 19 1964

APR 19 1964

APR 19 1964

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APR 19 1964

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Their places (remove carbon papers: Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.)

IMPORTANT: If item 21 is marked as "yes," it shows only injury, or other traumatic event, the medical examiner must be notified for autopsy.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		87 REG. NO. 11296							
1. DECEASED NAME (TYPE OR PRINT) <b>Tishie Anna Sneed</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>April 5, 1987</b>		2b. HOUR <b>9:30 P M</b>			
3 SEX <b>Female</b>		4 RACE <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 25 1893</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>93</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Alabama</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Elkton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Devine Haven Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Cleaning</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HouseWork</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Cecil</b>		13c. CITY OR TOWN <b>Elkton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>150 E. Main Street 21921</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Beverly Scott</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Suzanna Scott Harris</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>217-14-8478</b>		17 INFORMANT ADDRESS <b>Ruth S. Whiteman 209 North St. Elkton</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD. cardiac arrhythmia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Asthma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>[Signature]</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>4/7/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Julia Chih Hsu</b>				22e. ADDRESS <b>223 West main St. Elkton MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>APRIL 9, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Providence Methodist</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Elkton Cecil MD</b>			
24 FUNERAL DIRECTOR NAME <b>Geer Funeral Home</b> ADDRESS <b>259 E. Main St. Elkton MD</b>				25a. DATE REC'D. BY REGISTRAR <b>APR - 9 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

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4/20



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EX-100

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APR - 9 1987

051144 APR 21 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

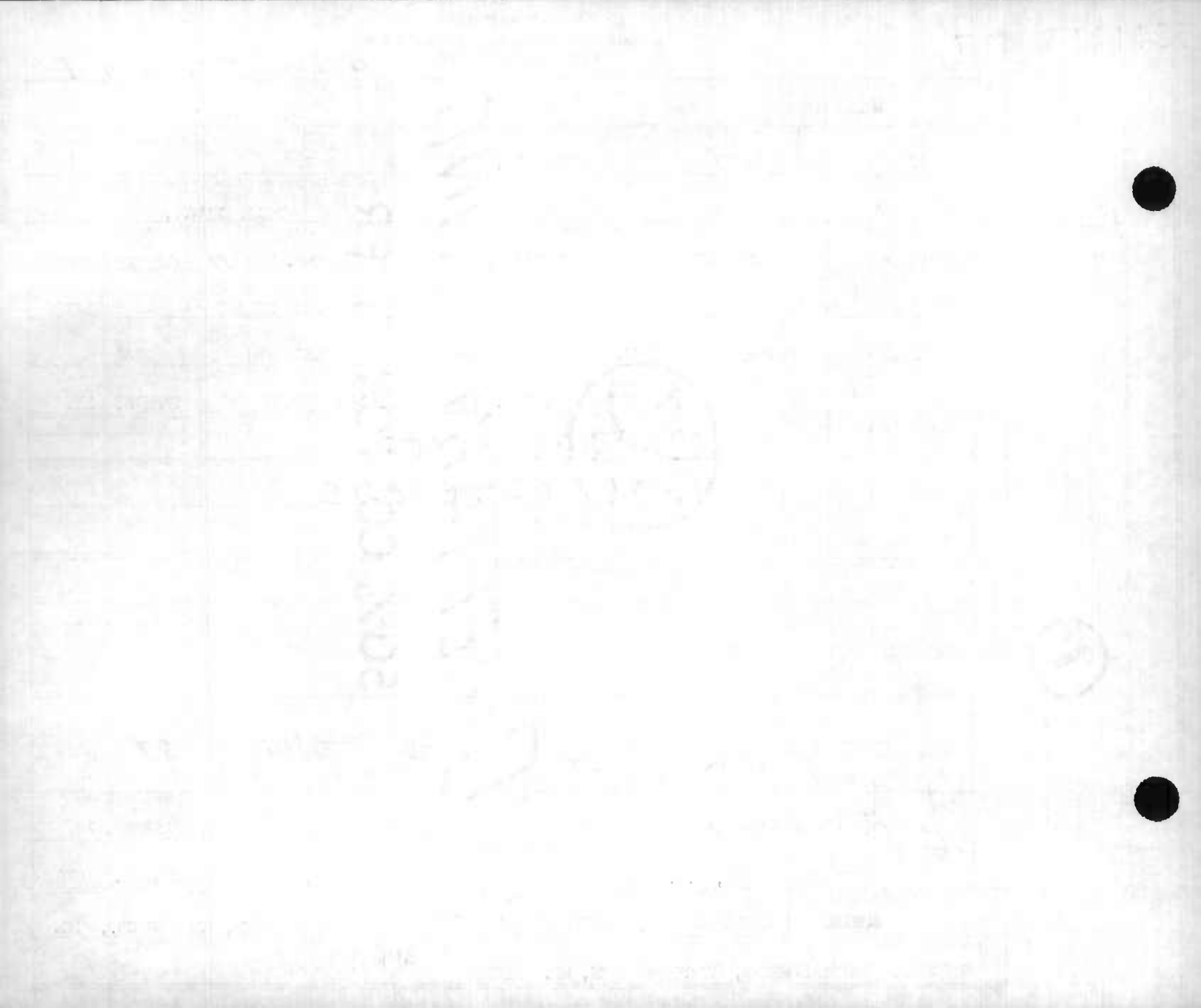
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial or cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B above, any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>William S Taylor</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>04 14 87</b>		2b. HOUR <b>8:00P</b> M			
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>AUGUST 20, 1907</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>CECIL COUNTY, MD.</b>				
10 CITY OR TOWN OF DEATH <b>RISING SUN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CALVERT MANOR NURSING HOME</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>(RET) MUNN. HANDLER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>FED GOVT (APG)</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>					13b. COUNTY <b>HARFORD</b>		13c. CITY OR TOWN <b>HAVRE de GRACE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM SAMUEL TAYLOR</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SARAH ELIZABETH VIAR</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>228 09 2694</b>		17 INFORMANT <b>MRS. CARRIE MILLICENT TAYLOR</b>			ADDRESS <b>SAME AS #13e</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>4/14</b> , 19 <b>80</b> , to <b>4/14</b> , 19 <b>87</b> that (I) (we) lost saw the deceased alive on <b>4/14</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Dante H. Monakil</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>15APRIL87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DANTE MONAKIL, M.D.</b>				22e. ADDRESS <b>622 SOUTH UNION AVENUE, HAVRE de GRACE, MD. 21078</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>17APRIL87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ANGEL HILL CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>HAVRE de GRACE, HARFORD CO., MO.</b>				
24. FUNERAL DIRECTOR NAME ADDRESS <b>MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078</b>				25a. DATE RECEIVED BY REGISTRAR <b>APR 20 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Frederick L. Sanders</b>				



050297 APR 15 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 7 REG. NO. 1 1 2 9 8

1. DECEASED NAME (TYPE OR PRINT) Ira W. Terry			2a. DATE OF DEATH MONTH DAY YEAR 4 6 87		2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 06 01 88		6. AGE (IN YEARS LAST BIRTHDAY) 98 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hopewell, PA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.		
10. CITY OR TOWN OF DEATH Rising Sun	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Manor Nursing Home, Inc.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pattern maker		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE PA	13b. COUNTY chester	13c. CITY OR TOWN Oxford	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 212 South 5th St. 19363
14. FATHER'S NAME FIRST MIDDLE LAST Ira Terry		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Toy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) unknown		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 164-10-7643		17. INFORMANT ADDRESS William Mauldin 128 South 6th st. Oxford, PA	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHF, heartblock, bradycardia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>A.S.C.V.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>about 1 year</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <u>UTI, Papillary carcinoma of bladder, COPD, hypothermia</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>19 80</u> to <u>4-6 19 87</u> that (I) (we) last saw the deceased alive on <u>Mar 31, 1987</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Faye R. Doyle MD</u>		DEGREE		22c. DATE SIGNED <u>4-8-87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FAYE R. DOYLE MD		22e. ADDRESS 133 Locust St Oxford, Pa - 19363			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/9/1987		23c. NAME OF CEMETERY OR CREMATORY Oxford Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Oxford Chester PENNA		24. FUNERAL DIRECTOR NAME ADDRESS Edward L. Collins 86 Pine St. Oxford, PA 19363			
25a. DATE REC'D. BY REGISTRAR APR 14 1987		25b. REGISTRAR'S SIGNATURE <u>John R. Ruch</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The registrar certifies that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. That permit remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

4/14

91

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Handwritten notes, possibly a list or description, mostly illegible due to fading.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) <b>JAMES GABRIEL TIERNEY</b>					2a. DATE OF DEATH MONTH <b>April</b> DAY <b>7</b> YEAR <b>1987</b>		2b. HOUR <b>1:30pm</b>		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>JULY</b> DAY <b>12</b> YEAR <b>1923</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>OHIO</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CECIL COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>Perry Point, Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA Medical Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PORTER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>RESTURANT</b>	
13a. STATE <b>MARYLAND</b>					13b. COUNTY <b>ANNE ARUNDEL</b>		13c. CITY OR TOWN <b>LAUREL</b>		
14. FATHER'S NAME FIRST <b>THOMAS</b> MIDDLE <b>TIERNEY</b> LAST <b></b>					15. MOTHER'S MAIDEN NAME FIRST <b>CATHERINE</b> MIDDLE <b>NALLY</b> LAST <b></b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1942-1945</b>		17. INFORMANT <b>JAMES M. TIERNEY</b>		ADDRESS <b>2029 cumberland dr.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Aspiration</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic obstructive pulmonary disease</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <b>he</b> (this hospital) attended the deceased from <b>February 24</b> , 19 <b>87</b> , to <b>April 7</b> , 19 <b>87</b> . <del>for the deceased</del> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>VK Nellore</b>					DEGREE <b>Es</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>4-8-87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>VIJAY NELLORE, M.D.</b>					22e. ADDRESS <b>VA Medical Center, Perry Point, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>APRIL 10, 87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>QUANTICO NAT'L CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>TRIANGLE, VIRGINIA</b>			
24. FUNERAL DIRECTOR NAME <b>Bianca</b> ADDRESS <b>Cunningham Funeral Home, Alexandria, VA.</b>					25a. DATE REC'D. BY REGISTRAR <b>MAY 07 1987</b>				
					25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>				

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MAY 2 1964

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

052133 MAY 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 7 REG. NO. 1 1 3 0 0

1. DECEASED NAME (TYPE OR PRINT) Reba Isabelle Watson			2a. DATE OF DEATH MONTH DAY YEAR April 25, 1987			2b. HOUR M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 29, 1890		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.			
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Laurelwood Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House Wife		12b. KIND OF BUSINESS OR INDUSTRY	
13. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Cecil 13c. CITY OR TOWN Perryville						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13. STREET ADDRESS / ZIP CODE 524 Front Street, P.O. Box 296 21903	
14. FATHER'S NAME FIRST MIDDLE LAST William J. Barnard				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isabelle Hewett					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-54-3463		17. INFORMANT ADDRESS Frances W. Tucker, Perryville, Maryland.					

18. CAUSE OF DEATH Enter one cause per line for (a), (b) and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - Cardio Respiratory Arrest - DUE TO, OR AS A CONSEQUENCE OF Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) - DUE TO, OR AS A CONSEQUENCE OF Pneumonia (c) -		APPROXIMATE INTERVAL BETWEEN (b) AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/10 19 87 to 4/25 19 87, that (I/we) last saw the deceased alive on 4/25 19 87, and that (my/our) opinion death occurred on the date and hour and from the causes stated above, (I/we) did (did not) view the body after death.							
22b. SIGNATURE Joseph G. Lanzi M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/25/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph G. Lanzi M.D.				22e. ADDRESS Elkton, Maryland.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 29, 1987		23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Port Deposit, Cecil, Maryland.	
24. FUNERAL DIRECTOR NAME ADDRESS Lee A. Patterson & Son, Perryville, Maryland.				25a. DATE REC'D. BY REGISTRAR APR 29 1987		25b. REGISTRAR'S SIGNATURE Julia Gordon-Landree	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be retained by the funeral director, page 3 should be detached for use on the burial permit. Their license requires certain papers. Pages 1 and 2 should be filed - after 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked on item 18 shows only injury, or other traumatic event, the medical examiner must be notified at once.)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>FRANK E. WEITZ</b>						2a DATE OF DEATH MONTH DAY YEAR <b>April 29, 1987</b>		2b HOUR <b>8:30am</b>	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Jan. 26, 1927</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>60</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore</b>		7b CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil County, MD.</b>			
10 CITY OR TOWN OF DEATH <b>Perry Point, Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA Medical Center</b>				12a USUAL OCCUPATION (GIVE MOST OF WORKING LIFE) <b>Federal Protective Officer</b>		12b KIND OF BUSINESS, INDUSTRY	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE <b>Md.</b> 13c COUNTY <b>Baltimore</b> 13d CITY OR TOWN <b>Woodlawn</b>				13e INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13f STREET ADDRESS / ZIP CODE <b>1415 Ingleside Ave. 21207.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank H. Weitz</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Christine --- Hopf</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>				16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1951-62</b>		17 INFORMANT <b>Wife: Mrs. Naomi R. Weitz</b> <b>1415 Ingleside Ave.; Baltimore, Md.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac pulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Glioblastoma multiforme of the frontal lobe</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>21207.</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 7</b> , 19 <b>87</b> , to <b>April 29</b> , 19 <b>87</b> . and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.									
22b SIGNATURE <i>John Lonergan</i>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c DATE SIGNED <b>4-29-87</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN LONERGAN, M.D.</b>				22e ADDRESS <b>VA Medical Center, Perry Point, Md.</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>May 2, 1987</b>		23c NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn, Maryland 21207</b>			
24 FUNERAL DIRECTOR NAME <b>P.A. 21228</b> <b>Sterling Funeral Estate, Catonsville, Md.</b> ADDRESS <b>736 Edmondson Ave.</b>				25a DATE REC'D. BY REGISTRAR <b>MAY 1 - 1987</b>		25b REGISTRAR'S SIGNATURE <i>John L. Anderson</i>			

Geological Survey

Department of the Interior

Washington, D.C.

Office of the Chief Geologist

Washington, D.C.

Geological Survey

Department of the Interior

Washington, D.C.

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Washington, D.C.

Geological Survey

Department of the Interior

053135 MAY 12 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
1- STATE  
REGISTRAR

REG. NO.

302

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2b. DATE OF DEATH MONTH DAY YEAR			2b. HOUR								
ELDR0			0.			WESTGARD			April 19, 1987			5:50am					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			7. IF UNDER 72 HRS		
Male			White			July 8, 1908			78			MONTHS			DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
Minnesota			U.S.A.						Cecil								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Perry Point, Md.			VA Medical Center			Soldier Professional			U.S. Army								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE					
None			None			Washington, DC			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			3700 N. Capitol St, N.W.					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME														
Unobtainable			Unobtainable														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
Yes			WWII/Korean			468-05-0589			William F. Reed (Conservator)			1725 K. St., N.W.			Washington, D.C.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) Cardiopulmonary arrest																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
(b) Bronchopneumonia																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
			HOUR A.M. MONTH DAY YEAR														
			P.M.			19											
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION			CITY OR TOWN			COUNTY STATE					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						STREET											
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 21, 19 87, to April 19, 19 87. <del>XXXXXX</del>																	
and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If two doctors did not view the body after death, XXXXXX)																	
22b. SIGNATURE			DEGREE			22c. DATE SIGNED											
						4-20-87											
22d. PHYSICIAN (TYPE OR PRINT)			22e. ADDRESS														
MELECIA SANTOS, M.D.			VA Medical Center, Perry Point, Md.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			CITY OR TOWN COUNTY STATE					
Burial			05/08/87			Arlington National Cem.			Arlington, Virginia								
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
NAME			ADDRESS			MAY 11 1987			Julia Gordon-Rodgers								
Colonial Funeral Home, Falls Church, VA.																	

MEDICAL CERTIFICATION

999999

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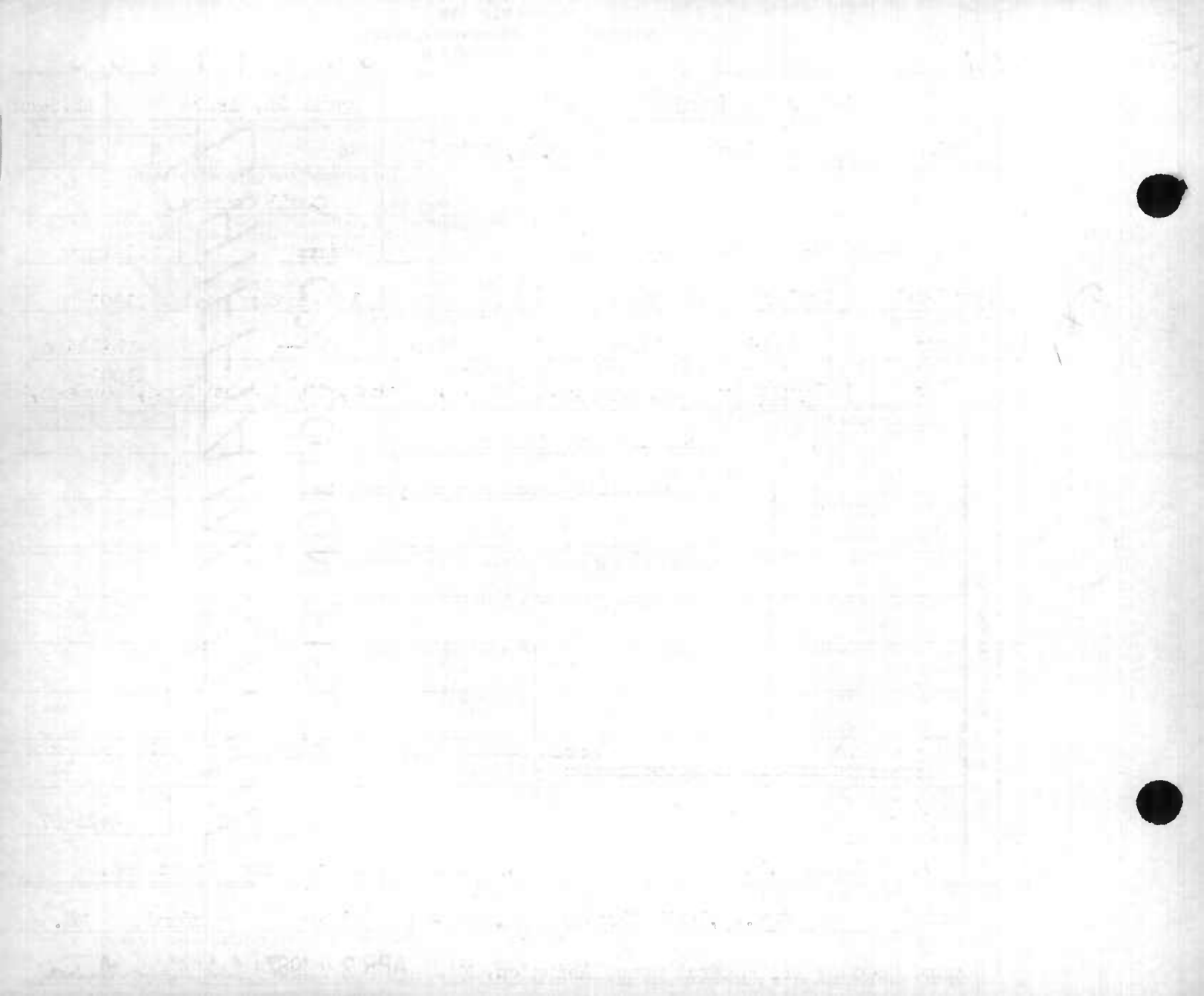
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate must be filed with this certificate.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 7 REG. NO. 1 1 3 0 3					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>THOMAS (nmn) WISE</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>April 22, 1987</b>				2b. HOUR <b>12:30am</b>	
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 24, 1922</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>64</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Mississippi</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil County MD.</b>			
10. CITY OR TOWN OF DEATH <b>Perry Point, Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA Medical Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Military</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>				13b. COUNTY <b>Harford</b>		13c. CITY OR TOWN <b>Aberdeen</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry (nmn) Wise</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Vida Phillips</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII-Korea-Vietnam</b>		17. INFORMANT ADDRESS <b>21001 Alexandra Bates, 109 Osborn Road, Aberdeen, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic carcinoma of prostate</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 30</b> , 19 <b>87</b> , to <b>April 22</b> , 19 <b>87</b> <del>XXXXXX</del> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, if (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>V.K. Nellore</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>4-23-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>V. NELLORE, M.D.</b>				22e. ADDRESS <b>VA Medical Center, Perry Point, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Apr. 25, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harford Mem. Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Aldino Harford Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Howard McComas III Funeral Home, Abingdon, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 24 1987</b>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Parker</i>			



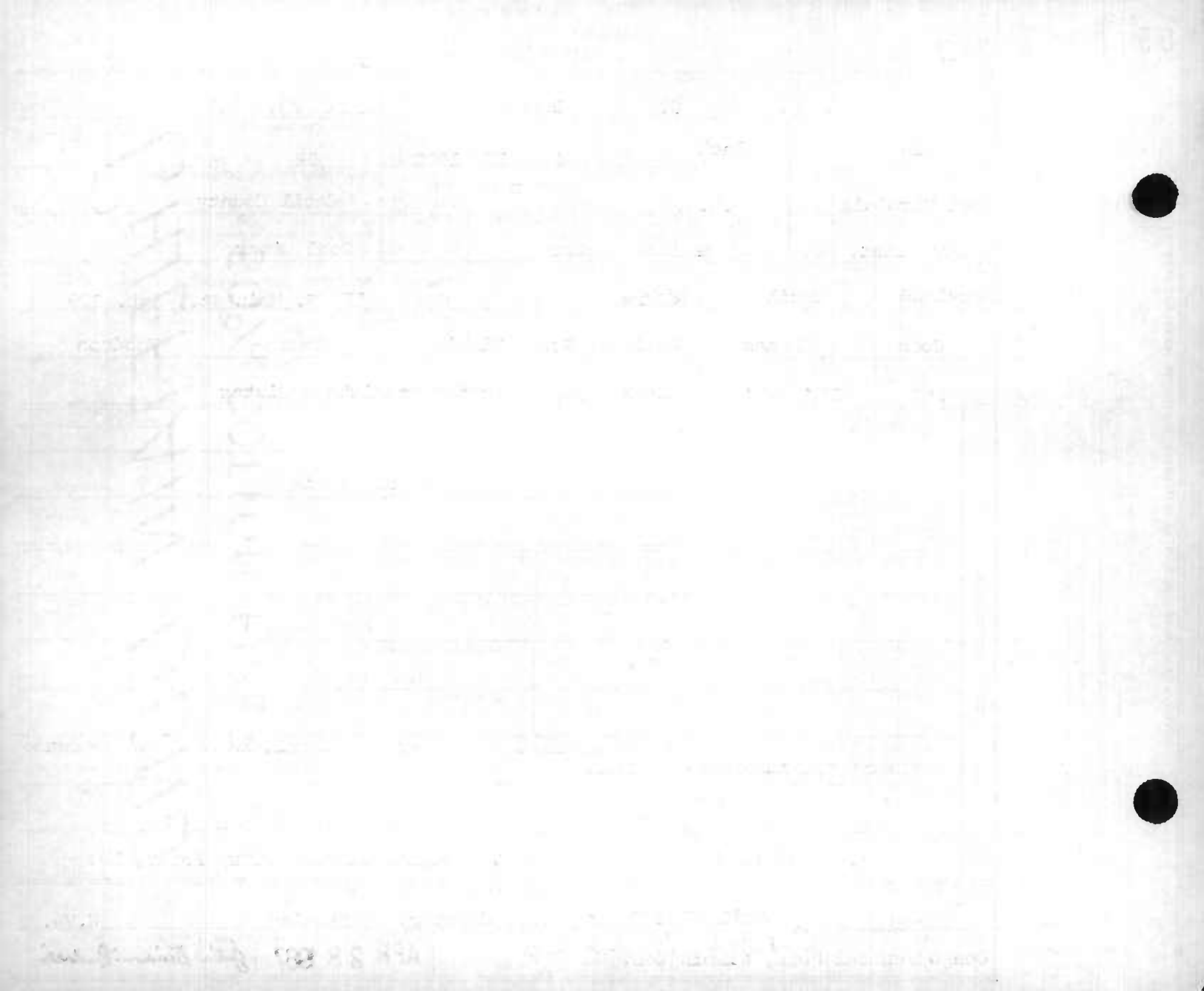
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and place them in the envelope provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR STATE REGISTRAR		87 REG. NO. 11304	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH MONTH DAY YEAR	
LEROY C. WOODSON		April 23, 1987	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS (LAST BIRTHDAY))
Male	Black	4 27 1928	58 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
West Virginia	U.S.A.		Cecil County MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Perry Point, Md.	VA Medical Center	Coal Miner	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
Maryland	Cecil	Elkton	
14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	13e. STREET ADDRESS / ZIP CODE	
John Thomas Woodson, Sr.	Pinkie Toney Woodson	150 E. Main St., Apt. 309 21921	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT ADDRESS	
YES	10/52-3/54	Dorothy Bessicks - Sister	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of lungs with metastasis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 3, 1987, to April 23, 1987. <del>XXXXXX</del> <del>XXXXXX</del> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Roy W. Chesnut, J. M.D.		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROY W. CHESNUT, M.D.		22e. ADDRESS VA Medical Center, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	April 27, 1987	Greenwood Cemetery	Beckley W. VA.
24. FUNERAL DIRECTOR NAME ADDRESS Congo Funeral Home, Wilmington, DE		25a. DATE REC'D. BY REGISTRAR APR 28 1987	
		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	



052319 MAY - 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

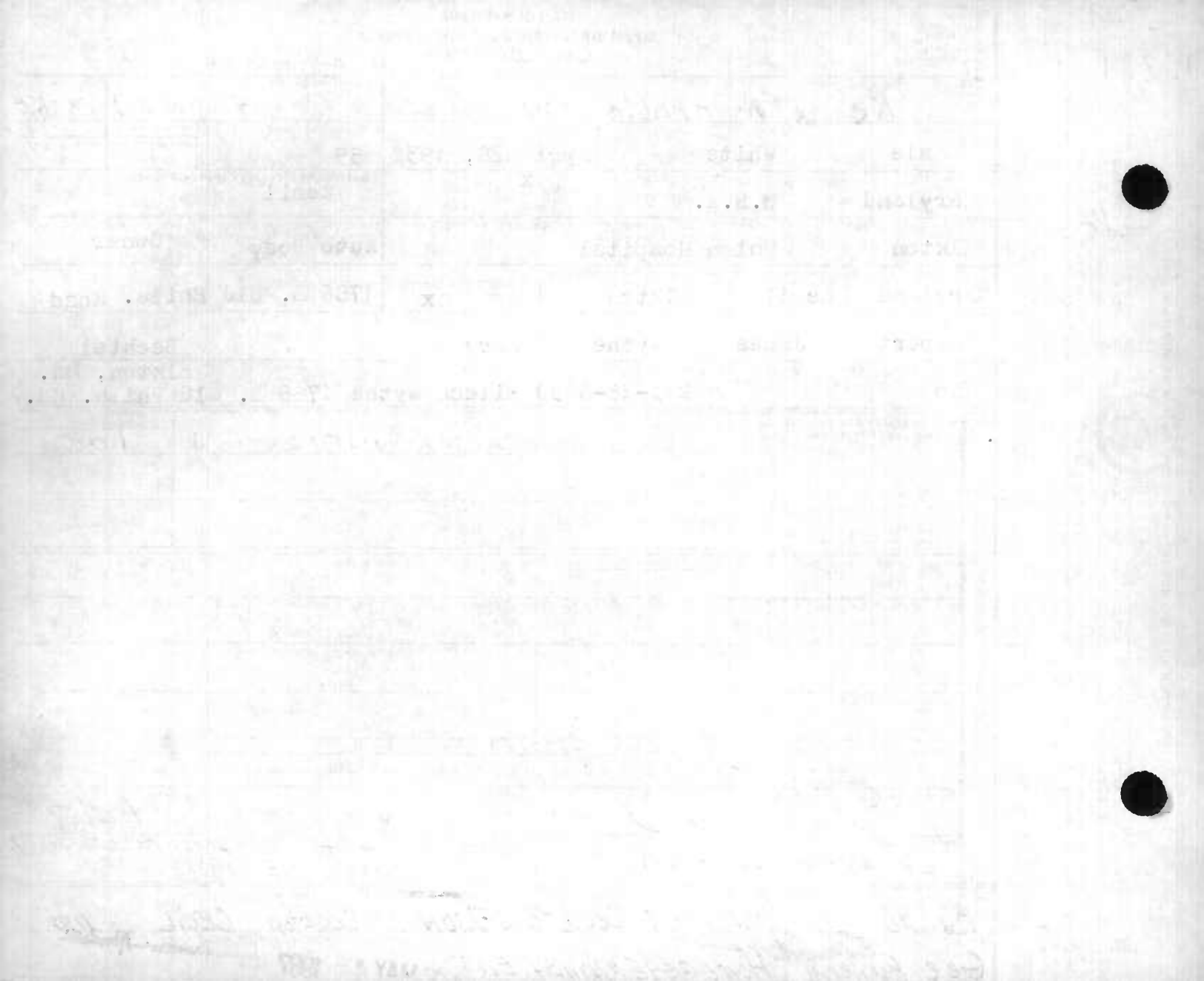
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87 REG. NO. 11305

FOR 1. STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		4 28 87		0335 <sup>AM</sup>	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		White		April 28, 1932		55	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		U.S.A.				Cecil	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Elkton		Union Hospital		Auto Body		Owner	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		Cecil		Elkton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		No		213-28-6230	
Albert James Wythe		Mary Bechtel		17. INFORMANT		ADDRESS	
				Eileen Wythe		Elkton, Md.	
				1786 E. Old Phila. Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYO CARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <u>4/27/87</u> , 19 <u>87</u> , to <u>4/27/87</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>4/27/87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
27b. SIGNATURE				DEGREE		27c. DATE SIGNED	
<u>Ehsanur Rahman MD</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		<u>4/25/87</u>	
27d. PHYSICIAN'S NAME (TYPE OR PRINT)				27e. ADDRESS			
EHSANUR RAHMAN				501 E 131, 4745 STANTON - OGLETOWN RD, NEWARK, DE 19713.			
23a. BURIAL, CREMATION, REMOVAL (PRECISE)		23b. DATE		23c. NAME OF CEMETERY OR OTHER PLACE		23d. LOCATION	
Burial		MAY 11 1987		CECILTON-ZION		CECILTON CECIL MD	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	
Gee FUNERAL HOME		MAY 4 - 1987					

BP



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Their please remove registration papers. Pages 1 and 2 should be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					87 REG. NO. 11305				
1. DECEASED NAME (TYPE OR PRINT) Daniel Zubrinitz					2a. DATE OF DEATH MONTH DAY YEAR April 29, 1987			2b. HOUR 11:25P <sub>M</sub>	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Feb. 15, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 72		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) Johnstown, Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.			
10. CITY OR TOWN OF DEATH Perry Point, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center				12a. Computer Operator		12b. KIND OF BUSINESS OR INDUSTRY Sec. Security	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN Maryland Baltimore Middle River					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3 HoneyComb Rd. 21220		
14. FATHER'S NAME George Zubrinitz					15. MOTHER'S MAIDEN NAME Mildred Kress				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 196 09 6284		17. INFORMANT ADDRESS Alice J. Zubrinitz, Wife. Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic encephalopathy and renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Liver cirrhosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>11-20-</u> 19 <u>86</u> , to <u>4-29-</u> 19 <u>87</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>4-29-</u> 19 <u>87</u> , and that in <u>xxx</u> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>D. Bouchette</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 4-29-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL BOUCHETTE, M.D.				22e. ADDRESS VAMC, Perry Point, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/2/87		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.			
24. FUNERAL DIRECTOR <u>Bruzdinski Funeral Home, Baltimore, Md.</u>				25a. DATE REC'D. BY REGISTRAR MAY 1 - 1987		25b. REGISTRAR'S SIGNATURE <u>Jordan R. Rader</u>			

